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REPORT OF FIVE CASES OF THORACIC ANEURISM.

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Read before the California Academy of Medicine.

All of these cases fell under observation early in their course. In none of them was a diagnosis possible at that time. They show the difficulty of an early diagnosis of aneurism even when the disease is suspected and looked for.

Case I. *Aneurism Ascending Portion of Arch.*—This patient, age 33, was admitted on December 14th, 1893, from the Naval Hospital, Yokohama, with the diagnosis of valvular disease of the heart. On his hospital ticket it was noted that a murmur could be heard, loudest on the right side of the sternum at the junction of the fourth rib with that bone. On admission, the patient was dyspneic and somewhat cyanosed. There was visible pulsation of all the arteries of the upper extremities. The apex beat was below the nipple, extending to the left of it. It was very diffuse, and needed a hand to cover it. Percussion revealed enlargement of the area of superficial cardiac dulness in both diameters. On auscultation, a murmur could be heard in place of the second sound at the aorta. Posteriorly, over the lower lobe of the left lung, friction sounds could be heard. He complained of severe pain in the chest. To relieve his distress he was given hypodermic injections of morphine. This was the only drug that gave him any ease. All the ordinary heart tonics were used without effect: digitalis, caffeine, strychnine, strophanthus, and nitroglycerine. Morphine acted best when combined with atropine. December 21—Pulse began to grow rapid and feeble; breathes easiest when sitting in a chair; edema of lower extremities. December 25—Sudden increase in dyspnea. December 26—Cyanosis increasing. December 30—Edema of lower extremities much increased. January 1—It was noticed that the integument of the fourth toe of the left foot and the third toe of the right foot was gangrenous. There was also a gangrenous patch on the outer side of the left foot, just below the external malleolus. He still continued to sit upright in a chair with his head hanging over the back. For a few days he rallied; the sloughs separated; his dyspnea decreased. January 7—Edema appeared in the left arm. This continued to increase, although he was fairly comfortable as regards his dyspnea. On the 14th another paroxysm of dyspnea appeared. From now on the paroxysms appeared with increasing frequency and severity until his death, on the 19th.

Autopsy: At the autopsy the heart was found to be very much enlarged, being both dilated and hypertrophied. All the valves were sufficient except the aortic. The aorta was atheromatous. About half an inch above its origin from the heart was an aneurism the size of a pigeon's egg, communicating with the aorta and pressing upon the pulmonary artery. The aneurism was filled with clots, those near the circumference being laminated and hard; those near the center, soft, red and friable. The aortic valves were not diseased, but insufficient from the increased diameter of the heart consequent upon hypertrophy; this last being due to the increased resistance to the passage of blood through the pulmonary artery. In this case the aneurism was not thought of during life. It was interesting because of the great cyanosis and the paroxysms of dyspnea. Both of these symptoms owed their intensity to the pressure of the aneurism on the pulmonary artery.

CASE II. *Aneurism Descending Portion of Arch.*—Patient aged 46; no history of syphilis. For some months past he had complained of pain in his chest and shoulders. He applied to a medical officer, who examined him carefully, bearing in mind that the rheumatism, of which the patient complained, might be due to an aneurism; but he found no evidences of it. A month before admission the patient had a slight hemorrhage; the day before admission, January 26th, 1894, he had a severe pulmonary hemorrhage, the amount being estimated at 16 ounces by the physician who was called in, since which time there has been no recurrence of the bleeding. On admission, he complained of pains darting through his chest every few minutes, about the level of the fourth rib. He had a slight cough. At various times he raised clots of blood. He complained, also, of pain in his left shoulder, where there was a spot close to the tip of the acromion extremely sensitive to pressure. There was, also, on the dorsum of the left foot, close to the ankle, another tender spot. His temperature was 102.4°. From fear of provoking a hemorrhage, no examination was made this day. When examined, several days later, only the mucous rales indicative of hemorrhage were found. The treatment consisted of codeine, cracked ice, ergot, and morphine. January 29.—On the dorsum of the left foot was a blush extending from the base of the toes to the ankle. At 6:30 P. M. he had a rigor, followed by delirium which lasted all night. During this time he complained of severe pain in the left foot. It was noticed that the integument of that foot was very anemic as though the capillaries were strongly contracted. On the following morning the reason for all this was apparent. The toes and part of the foot were discolored with the mottled appearance of gangrene. The patient was very low from the moment of admission, and would not have been able to rally from the shock of an amputation. The gangrene spread upward rapidly. The septic symptoms became more marked. He died early in the morning of February 3d.

Autopsy: At the autopsy the aorta was found to be affected with atheroma. At the beginning of its descending portion there was an aneurism the size of a gull's egg, projecting into the left lung, and coming nowhere in contact with the chest wall. Posteriorly it rested on the bodies of the vertebræ which showed no effect from its pressure. In removing the lung the rupture of the aneurism was completed. A large clot fell out. Another clot was found in that portion of the aneurismal sac which had become agglutinated to the inner surface of the left lung. The sac exercised no pressure upon the left bronchus, and only a small pressure upon the esophagus. There was an embolus in the left popliteal artery.

This case is interesting because there was a large hemorrhage from rupture of the sac without an immediately fatal result. It was due to the fact that the bleeding occurred in a circuitous manner, the blood going through the parenchyma into the smaller bronchi.

CASE III. *Aneurism Transverse Portion of Arch.*—Age 56; no history of syphilis. He was admitted August 1, 1891, from the Naval Hospital, Yokohama, Japan. He complained of cough with greenish expectoration; of pain, which had lasted since November, 1890, situated in the sternal region, about the second and third right costal spaces. Inspection showed marked bulging over the upper sternal region, extending somewhat above and below the second and third costal interspaces. There was marked dulness over the tumor, and also a loud bruit on auscultation. Diminished respiratory murmur over the left lung, the diminution increasing toward the lower lobe. Dyspnea. The treatment consisted of absolute rest, with potass. iodid. gr. xx t. i. d. On August 6th the diet was limited to 10 oz. solids and 8 oz. fluids a day. This was continued until October 11th, when he was allowed to get up, having improved so much. The patient continued in this condition during the remainder of 1891, through 1892 and 1893 suffering frequently from attacks of bronchitis. Latterly there seemed to be a tendency for the aneurism to increase. On January 27, 1894, he was discharged to the Naval Hospital, Brooklyn. From there he was discharged from the Naval service. He went to his home in Scotland. When heard of six months ago he felt well except for the attacks of bronchitis. On March 11, 1895, he died from rupture of the aneurism internally during a severe attack of bronchitis. His case is interesting for the marked improvement which followed the treatment advocated by Tufnell.

CASE IV. *Aneurism Descending Aorta.*—This case was first seen at the moment in which he died. It was learned from the surgeon of the ship to which he was attached that he had suffered from persistent pain in the back. As in all cases where no objective symptoms can be found, he was suspected of being a shirk. On the day that I saw him he had suddenly complained of severe pain and weakness. Before any surgeon could reach him he was *in extremis*. The autopsy revealed an aneurism, the size of a small fist, which had proved fatal by rupture into the left pleural cavity. It had eroded the bodies of the sixth, seventh, and eighth dorsal vertebræ.

CASE V. *Aneurism Transverse Portion of Arch.*—Age 28; there is a history of syphilis. On admission he complained of precordial pain and tenderness, palpitation, dyspnea, and vertigo. There was a marked bulging between the lower border of the second left costal cartilage and the upper border of the fifth left costal cartilage. Its right border was 1 inch to the left of the sternum, its left border in the left mammary line. Tracheal tugging was present. On palpation of the tumor a marked impulse was transmitted to the hand. On ausculation a loud murmur could be heard over the tumor, and also over the entire heart; but the heart tones could be heard in addition to this. The treatment consisted of rest in bed with morphine to control the pain. On August 10th the patient fell under my care, and I determined to make an attempt with Tufnell's method. His diet was restricted as in the former case. In addition he was given potass. iodid. For a while he did not care to eat the quantity of food allowed. The morphine was continued. On September 4th he complained that the allowance of food was not sufficient. On September 10th the dieting was given up, as no good had been obtained from it. The patient suffered constantly, so that it was necessary to increase the morphine. The tumor also increased in size. On October 20th the pulsation seemed to have decreased in the tumor. Since that time the morphine has been constantly cut down, so that at the present moment he is receiving none. At different times he has suffered from severe attacks of palpitation, with increased pulsation in the aneurism. These were controlled by tinct. aconit. During all this time he maintained the recumbent position, though he had asked several times to get up. Later he was allowed to do so for a day. But the pain recurred with such severity that he was again put to bed.

A CASE OF COMPLETE OBLITERATION OF THE INFERIOR VENA CAVA.

By EMMET RIXFORD, M.D., Adjunct to the Chair of Surgery, Cooper Medical College, San Francisco.

Read before the San Francisco Medico-Chirurgical Society.

The following case is unusual, and presents a sufficient number of interesting features to warrant its being reported somewhat in detail:

Henry R——, 30 years of age, born in England, a bricklayer by trade, was admitted to the City and County Hospital for treatment of varicose veins and one or two small ulcers of the legs, on September 28, 1893. He gave the following history: He had enjoyed perfect health until 1884, when he was confined to his bed for six weeks in the Presbyterian Hospital, New York, with fever and pain in the abdomen. He had gotten the idea that this was typhoid. For some time after leaving the hospital he had constant dull pain in the legs and was annoyed by swelling, which he described as very great. Gradually, however, the swelling diminished as the veins on the outside of the trunk began to dilate. After a month or two he was well enough to return to his work of bricklaying, and has been able to pursue that occupation up to the present time, suffering no inconvenience other than that caused by moderate swelling of the legs.

On examination, the patient was seen to be well nourished and well developed in his muscular system. There was a moderate degree of edema of the legs, with one or two small ulcers as mentioned above. The superficial veins of the thighs and abdomen were enormously dilated on both sides. More specifically, a large group of dilated and tortuous veins extended from the inguinal region to the axilla on each side, another to the umbilicus and up the middle line to the neck. Many of the veins were as large as one's finger. The case was evidently one of obstruction of the inferior vena cava, probably due to post-typhoid thrombosis. There was a marked protrusion or diffuse fulness in the region of the liver on both sides. Palpation of the liver was made uncertain by the thick and rigid abdominal walls, but percussion showed the liver dulness to be increased, especially on the left side. No isolated tumor could be made out, so that it was clear that the liver was greatly enlarged. It was thought that this might be due to chronic passive congestion, assuming that the vein had been partially occluded above the point where the hepatic veins empty into it.

The legs improved rapidly under treatment and the patient was discharged on the tenth day, the ulcers having healed.

On January 29, 1894, he reëntered the hospital to be treated for several large ulcers which had recently formed. Thiersch grafts were applied and a rapid healing was effected, the patient being discharged on February 25th.

On December 13, 1894, he entered the hospital for the third time with the usual story of more ulcers. He had gotten along very comfortably as long as he had worn proper bandages, and he had been able to work at his trade. Rest in bed and suitable dressings soon enabled the ulcers to heal, when, with legs regularly bandaged by the nurse, he was able to work about the hospital for a number of weeks, feeling as well as ever.

On January 31, 1895, the following note was made in the records: "The patient has been feeling badly for several days; has loss of appetite and complains of pain in the abdomen; he is slightly icteric, the conjunctivæ being tinged with yellow. He is somewhat constipated. Calomel in small doses, was given."

February 19th: "Patient has been doing well for the last two weeks, but is now feeling badly again, and is icteric. He has some fever and complains of pain in the abdomen. He was transferred to the medical ward and was examined under ether by Dr. Hirschfelder, when the following observations were made: 'The liver dulness in the right mammary line is 11 centimeters. The liver is somewhat harder than normally; the edge is rounded, but not well defined. An indefinite tumefaction, perhaps two inches in diameter, below the liver and to the right of the median line, is felt. This tumor seems to be separated from the liver."

The temperature record for the next few days showed an irregular course, varying from 98° to 103°. The diagnosis of abscess of the liver was made and the patient transferred back to the surgical ward for operation. The inflammatory symptoms began to abate, however, and operation was delayed. On February 26th he became suddenly worse; temperature 104°; great pain in the abdomen; considerable tympanites, and on the next day he died.

Autopsy: The autopsy showed a moderate amount of peritonitis about the right hypochondrium. The adhesions resulting from this had given rise to the tumor mentioned above. The liver was enormously enlarged, the left lobe being larger than the right lobe originally is, and the right enlarged in proportion. The right lobe was almost completely taken up by two very large cysts. These cysts were filled with a thin, dark-colored fluid, with fecal odor, containing more or less cellular elements and large masses of dark material in flakes resembling gall-stones. The walls of the cyst were about a quarter of an inch thick, and composed of firm white fibrous tissue. In places there were large flat pieces of this gall-stone material imbedded in the walls. The larger of the two cysts had a hernial protrusion downwards behind the transverse colon with thin walls, and to this was adherent the inflammatory tumor described above. It was evident that the localized peritonitis was due to perforation of this hernial protrusion, and was the immediate cause of death. The gall bladder contained a number of gall-stones and some fluid—chiefly mucus.

Search for the inferior vena cava revealed that vessel buried beneath a mass of exceedingly firm, white scar tissue, which made the dissection tedious. The vein was completely filled with a firm fibrous cord, which contained in places calcareous deposits resembling bone. The fibrous cord extended well down into the iliac veins below, and as far as the diaphragm above. There were several small veins running parallel to it embedded in the surrounding fibrous tissue. The kidneys were both enlarged and much harder than normally, and congested. Probably this induration was the direct result of chronic passive congestion due to partial destruction of the renal veins.

I am indebted to Dr. Bertram H. Waters, House Physician to the Presbyterian Hospital, New York, for the clinical history of the case when in that hospital, in 1884, which throws considerable light on the cause of the trouble. The diagnosis then made was double femoral phlebitis. The following is quite a full abstract of the history:

Henry R——, aged 21, England, bricklayer, single, entered the hospital May 30, 1884. He felt perfectly well until three weeks ago. For one week he had daily epistaxis, and felt badly. The bowels were regular. He had some pain in the abdomen on locomotion. For the past two weeks he has been in bed, during which time the bowels have been inclined to be constipated, and the pain in the abdomen has increased. There has been occasional vomiting and slight fever, but no cough. For the past three days the left leg has been painful and swollen. On admission the general condition was good, face flushed, temperature 100.5°. Patient complains of pain across the abdomen, extending down the inner side of the left leg. Patient vomits after taking food. He was ordered rest in bed and given a soap-suds enema. On the next day the bowels moved freely, and the patient was given milk and lime water. Belladonna ointment was applied locally.

On June 4th, the temperature was lower and the general condition better; the swelling of the limbs had somewhat subsided. On June 12th, the swelling had entirely disappeared, but the patient began to complain of pain in the popliteal space of the other leg, and there was some fever. On June 14th, the right leg was swollen throughout and painful, and on the 16th, the swelling was apparently stationary. The patient was allowed some solid food for the first time. On July 6th, patient was discharged cured.

From this history it is probable that the vena cava was the seat of inflammation at the same time as the femoral veins. This would explain the abdominal pain and the subsequent course of the trouble and the findings at the section. The fact that the remains of the vena cava were found imbedded in a great mass of well-organized cicatricial tissue, shows that there must have been a periphlebitis of considerable extent and severity. A thrombus formed in the femoral vein or the iliac might extend by simple addition of coagulum throughout the whole vena cava, but this would not be followed by evidence of inflammation outside of the vessel. Hence there is very good reason for supposing that the inflammatory process involved the greater part of the ascending vena cava.

The liver abscesses were probably of metastatic origin, yet they might have resulted from an extension of the inflammatory process upwards through some of the radicals of the hepatic veins. That they date from the time of this illness in the Presbyterian Hospital is probable. At least, it must have taken a long time to cause the formation of the well-organized thick abscess-walls, and for the deposition of such large quantities of biliary products in the abscess cavities. The process must have been an exceedingly slow one to have produced so great a destruction of liver substance without more definite symptoms referable to the liver, and, more than all, it must have taken a very long time for the compensating hypertrophy of the left lobe of the liver to have taken place to such an extent as to enable it to perform practically the whole of the function of the organ, for, it will be remembered, there was almost no liver substance left in the right lobe.

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FIVE CASES OF ANTEMORTEM CLOT.

By B. M. GILL, M.D., Dunsmuir, Cal.

Read before the California Northern District Medical Society.

CASE 1. My first case of thrombosis was difficult to diagnose. J. W——, aged 34, was suffering with pain in different localities representing all the region supplied by the sacral plexus. At first I was inclined to call it a case of sciatica, but after careful examination I arrived at the conclusion that the posterior tibial artery was occluded. There seemed to be almost a total lack of blood supply to the region of distribution of that artery. I immediately ordered dry hot applications to the foot, thereby hoping to keep the temperature at as near normal as possible. I also directed absolute quiet. The bowels were moved with an alkaline laxative, and followed with potassium iodide. After three days the collateral circulation was sufficient to discontinue the warm applications, and about a week later I could find a weak pulsation of the artery at the ankle. Recovery was perfect and, as far as I know, permanent. Were I to treat a case like it again I should supply heat by a constant stream of water at a temperature of 100° running over the affected part.

CASE 2. A miner, living alone. In May, 1891, was called to see Peter O——, aged 55. He was sitting up, and made no complaint except that he could not sleep. His face was swollen and suffused; the veins of his neck and temples were greatly distended, and everything pointed to an obstruction of the return circulation. The heart sounds were such as to indicate a possible clot in the right heart. My diagnosis was a clot in the right auricle. I ordered absolute quiet until I should come again, but expected that I should not see him alive. At 6 P. M. I found him much worse. As he requested something to make him sleep, I gave him about 10 grains of potassium bromide, which I afterwards learned he did not take. Early the next morning I called a friend and we went to his cabin finding him dead. He had evidently retired, and died at once without a struggle. On returning about noon from a call in the country I was told there was much talk among the people that I had given him a sleeping powder, and that he had gone to sleep and never awoke. I immediately called some citizens to witness the autopsy. On opening the thoracic cavity I found it full of blood, which, on being removed, revealed the descending vena cava which was torn its whole length, and from appearances had been dilated to as much as two inches and a half in diameter before the laceration took place. There was a history of hard drinking, and that a small amount of food had been taken of late.

CASE 3. M. B——, aged 55; laborer. Thrombosis of the superficial and transverse perinal arteries; considerable pain and tenderness, but no swelling or appearance of abscess. Two days later all that region including the posterior scrotum became gangrenous, and sloughing began. Lines of demarkation soon appeared, and all of the superficial perineum and some portions of the deep structures near the rectum sloughed away. The sphincter ani muscles were left intact. Careful cleansing and antiseptic treatment resulted in perfect recovery.

CASE 4. M. T——, aged 50; a night watchman at Castle Crag Tavern. I was called September 22, 1893. The patient had suffered for a short time with severe pain "in the heart," and thought he was about to die. The next morning he had pain in his right arm near the axilla. When I first saw it the arm was much swollen; the arterial circulation was good, but the venous circulation was apparently much diminished. My diagnosis was a clot in the basilic vein. I ordered perfect rest, and not to allow the arm to hang down. I also directed that no massage or exercise should be permitted, and advised that he consult physicians in San Francisco. I afterwards learned that one doctor kept the arm suspended for several days, also that the swelling became much worse. One year later he had not recovered perfect use of the arm.

CASE 5. James McI——, laborer. Injured at 8 A. M. Dr. Tregloan, my associate, saw the case first. I was called in consultation at noon, and found a double compound fracture of the skull. We trephined and removed 23 fragments, uncovering about four square inches of dura mater. A small spicula of bone having pierced the membranes, about a thimble full of brain substance exuded. The wounds were dressed antiseptically, and patient rallied nicely. The injury occurring so soon after eating, the food decomposed and much of it escaped by emesis. Thirty-six hours after injury he suddenly collapsed and died, apparently of pulmonary congestion. An autopsy revealed only the left lung affected and thrombi in the pulmonary arteries. A possible solution of the thrombosis of the pulmonary artery was, that owing to the great loss of blood and the lack of fluids the excessive acid fluids were absorbed in greater quantity than otherwise would have occurred, thus charging the blood with chemical properties that would tend to clot formations.

Different causes have been assigned for thrombosis in different cases, and no one cause can be general, yet it is possible that a cause can be suggested that will apply to a large portion of cases. Occlusion by ligature, inflammation, septic, syphilitic or otherwise, aneurismal dilatations, pressure, and possibly heart failure, may all be causative factors, but more common, and by far, especially when affecting veins, is either inflammation of the vein itself or the chemical condition of the blood, which is very probably a frequent cause of coagulation. In support of this theory I will quote from Salisbury on "Alimentation and Disease," as follows:

"If either animals or men feed upon sour foods or drinks which are undergoing or have undergone acid fermentation or upon foods not yet sour, but sure to become so when they enter a digestive apparatus already charged with acid yeasts, the sour products pass more or less rapidly into the circulation, making a blood acid, sticky, ropy and adherent, and the fibrin filaments tough, larger and shorter. These changes cause a partial clotting of the blood in the blood stream. This partial clotting makes the blood mucilaginous, adhesive and stringy. It also makes the sticky, colorless corpucles and fibrin filaments liable to fasten themselves to the walls of the vessels.

"The most favorable place for these attachments to take place is at or near the heart. They are at first small, consisting of a few sticky cells and filaments; these minute beginnings grow by constant additions from the sticky materials of the blood stream; they become long and flaggelate and their growing masses are constantly whipped by the flowing stream. The place of attachment is usually small, the mass becoming bellied or fusiform, tapering at both ends and growing more rapidly in the middle. Thrombosis is the name of this condition. Sooner or later these thrombi are liable to break from their fastenings, when they go floating along in the blood stream as emboli. Now comes in the danger of embolism, or the sudden plugging up of the smaller arterial extremities and capillary vessels. As long as the thrombi remain anchored, or held to their fastenings, there is but little danger of death, although they may produce great discomfort. The more quiet the mental and physical state, the less the danger of tearing them loose. The greater the exertion, the greater the danger. When they do break loose and block up the capillaries and smaller arterial extremities in any organ, a sudden damming up of the blood in that part takes place, accompanied often by 'trip-hammer' pulsations of the heart, effusion of serum, inflammation, and frequently the rupture of bloodvessels in the part or parts, followed by death in from four to forty-eight hours.

"This is precisely what occurs in animals and men, when sour foods—too exclusively and continuously eaten—produce too great and rapid acidity of the blood. This often occurs in the disease in swine known as 'hog cholera,' or consumption of the bowels, and in man sometimes in the so-called chronic diarrhea, or consumption of the bowels. Both of these diseases are phases or states which which may arise from too rapid infiltration, or saturating the system too quickly and suddenly with acid and acid yeasts. The same foods that produce these states might be taken without serious results, if they could be given in small quantities at first and gradually increased, allowing the various organs to accustom themselves to caring for and eliminating the deleterious products, so that they should not accumulate in the system. This mode of taking such foods, combined with proper exercise and surroundings, would maintain a passable condition—though not a healthy one—for a long time.''

While I should, in the main, agree with the distinguished author, I should yet disagree as to the acids passing into the blood as acids. All acids must necessarily enter the blood in a more or less neutral state. Yet it is possible, when there is present in the alimentary canal continuously a large amount of acid products of fermentation that the exact equivalent is not maintained, and the compounds may be more acid than neutral. The natural alkalinity of the blood would then be reduced to a minimum. Instances may occur where the patient has lost a large quantity of blood, when the alimentary canal was loaded with sour products. The sudden demand for fluids would then cause an absorption of fluids chemically incompatible with a normal condition of the blood. Again, an individual might lose a great quantity of blood shortly after the ingestion of a full meal. During the time which he would lie in shock, the food would undergo fermentation, and upon the return of a better circulation, the demand for additional fluids to keep up a proper equilibrium might cause the absorption of acid products incompatible with natural conditions.

A sudden pulmonary apoplexy or a heart clot might seem very inexplicable to the attending physician. Some fourteen years ago I investigated an epidemic of hog cholera in Wisconsin. In one large herd I found the so-called "hog-cholera" was nothing more than an epidemic of acute tuberculosis. The sputa of the sick beasts being eaten by the well ones contaminated the whole herd. One particular symptom of all cases of true hog cholera in the last stages was what the farmers called "the thumps." The animal would seem to beat or thump all over. Every one so taken died. Cyanosis prevailed. The ears were blue and cold; every symptom showed more or less impeded return circulation. *Post-mortem* examinations always revealed a diseased and clotted condition of the blood in different parts of the body, particularly the lungs and mesentary, all showing a general deteriorated condition of the blood, which was undoubtedly due to unwholesome food. It was a noticeable fact that the animals would greedily devour charcoal, wood ashes, rotten wood, etc.

I have killed over one hundred deer in my life, and although I have looked for pathological conditions and found some, I have never seen any organ or part of these animals that showed any diseased condition which could have been caused by thrombi. As a rule, all ruminating animals will travel far to reach springs of saline and alkaline waters, and tarry long in their vicinity. These lessons which instinct teaches the wild animals should, in a measure, serve as a lesson to man in the selection and preparation of foods for himself and for domestic animals, particularly those which furnish meat and milk.

SUCCESSFUL TREATMENT OF PROLAPSUS UTERI BY A NEW SURGICAL PROCEDURE, WITH A REPORT OF TWO CASES.

By B. Sherwood-Dunn, M.D., Paris, France.

Since the publication, in 1889, of the excellent monograph by Robert Asch upon vaginal hysterectomy for prolapsus uteri, that operation has found considerable favor in Europe; but it is to my esteemed and celebrated chief, Professor Pozzi, that the credit is due for an operation equally radical in its curative results, but devoid of the capital character and danger of the first-named procedure.

The first of the two following cases was that of a woman 68 years of age. The uterine prolapsus commenced after her first and only childbirth, at the age of 29, gradually increasing, until at 35 it protruded from the vaginal orifice after any great physical effort or fatigue, accompanied by incontinence of urine. The vaginal walls also became lax and partially prolapsed, which condition served, when the uterus was well reduced to its normal situation, to support it in place. There was no pain or complication in the uterine appendages.

When the patient came to Broca Hospital she complained that except she first adjusted the uterus she could not sit comfortably, and that it was necessary to reduce it so frequently, and the incontinence of urine had become so troublesome, that she decided to seek relief. Nineteen days after the operation the wounds were healed, the incontince completely arrested, and even with the greatest effort she could cause only a slight opening of the vulva with no protrusion.

The second case was that of a woman of 42, the mother of seven children. She commenced menstruating only at the age of 18, and ceased after the birth of the seventh child. At the age of 25 or 26 she was 36 hours in labor with the third child, which was born with the aid of instruments. It was after this childbirth that she had the first symptoms of prolapsus. At the age of 37 or 38 she had her seventh normal childbirth, breech presentation, after 30 hours of labor; and since this time complete prolapsus of the uterus could be affected at any time by the patient pressing down, and it protruded constantly when she stood or walked. The uterine annexia were free from complication, but in this case the patient could not urinate when the uterus was prolapsed.

Ten days after the operation the surfaces were practically healed, and the present indications are that the result will be fully as good as in the first case. Knowing the conservative character of American surgery, I may be excused for detailing the steps of this operation *in extenso*, as I am impressed that it will supercede the several other procedures for like conditions.

The uterus is seized by tenaculum forceps and drawn outside the vulva. Commencing about half way between the urethral opening and the os uteri, an incision is started on the anterior superior surface and carried diagonally downward to a middle lateral point, about half way between the point of incision and the os uteri. From this point the incision is carried diagonally backward and downward to a middle point on the posterior inferior surface. A corresponding incision is made on the opposite side from the commencing to the ending points, making two somewhat V-shaped flaps, with the apex of the V rather U-shaped. These incisions are found to be above the uterine arteries, which are ligated. Then the anterior part of the mucous membrane incised is seized by forceps and dissected downward a short distance. Passing a male catheter into the bladder to protect this organ from accidental injury, the mucous membrane posterior to the incision, which is to form the flaps to be united later on, is dissected upward to the limits of the cervix, taking care not to enter the peritoneal cavity, at which point it is amputated from the body. The uterine canal is cauterized for a short distance by aid of the round point of the thermo-cautery; then by three superimposed layers of catgut sutures, the denuded surfaces left by the dissection are brought together (the same as in a colpo-perineorrhaphy after Martin's method), then the two lateral flaps are brought together over the uterine stump, closing it in, first, however, introducing a drain of iodoform gauze into the uterine cavity. This completes the first part of the operation, which really forms a colporrhaphy over the amputated uterus.

The second part of the operation consists of a perineorrhaphy after the method of Lawson Tait. A horizontal incision of about three inches in length is made at the juncture of the perineum with the vaginal opening, and the upper and lower sections are freed by dissection upward and downward. A silver wire is passed through from one end to the other of the incision, and when brought together and twisted makes a puckered opening above and below the suture. These are in like manner sutured with silver wire—one to each—and remained closed by aid of horsehair sutures. This transforming of a horizontal incision into a perpendicular sutured opening reduces the vaginal orifice very sensibly.

15 Rue des Pyramides.

GLIOMA OF THE RETINA, WITH A REPORT OF TWO CASES.

By Wm. Ellery Briggs, M.D., Sacramento, Cal.

Read before the Sacramento Society for Medical Improvement.

In the early part of the century Beer gave the name of ''amaurotic cat's eye'' to the disease which has since been described under the names encephaloid cancer, medullary sarcoma of the retina, pseudoglioma, glio-sarcoma, etc., that is now recognized as glioma of the retina. It may form glio-sarcoma in connection with a new growth of the choroid.

Histologically the growth resembles the granular cells of the retina, from which it always originates, and it is the only tumor having its origin in the retina. It is sometimes congenital; nearly always appears during the first three or four years of life, and never occurs after the twelfth year.

The first symptom usually noticed is a light grey or yellow reflex from the ocular fundus. This appearance resembles the reflex seen in some animals, when in the shadow looking towards the light. This symptom is seen in other conditions, but when found in infants it is due to glioma, some suppurative disease in the vitreous or uveal tract, detached retina, cysticercus, choroidal sarcoma, or tuberculosis. In suppurative disease there will be evidence of inflammation, and the ophthalmoscope and focal illumination will aid in differentiating between the two conditions. In glioma the surface of the growth will be seen to be uneven, with vessels coursing over it.

The lesion first appears as small nodules which enlarge and become confluent, or extend by infiltrating the tissue adjacent to the growth. Finally the whole retina becomes involved except at the optic disc and ciliary process. The choroid is attacked by invasion of the glioma cells, then the lens and iris are involved until the whole eye becomes filled with the new growth. The sclerotic and cornea become ectatic and give way at one or more points. At these places staphyloma are produced as the intra-ocular pressure becomes increased. Sooner or later the cornea becomes necrotic, and the eye appears as a red fungating mass partly covered with crusts.

The glioma cells reach the brain by following the course of the nerves and vessels through the sclerotic coat, and then extending through the orbital roof, or by following the optic canal which becomes perceptibly enlarged. The cells invade the neighboring osseous tissue and gradually extend to the cavities in that vicinity.

If the growth ever atrophies it is so rare that most observers believe it never happens. After having reached the brain the cerebral mass may attain considerable size before it produces any symptoms. Metastatic tumors occur in most of the viscera and in other tissues of the body. After removal the growth often recurs either in the cut end of the optic nerve or in the orbital tissues, even when metastatic infection of the brain or other tissues has not taken place. After such recurrence the growth of the tumor is usually rapid, and death soon follows from marasmus, or from metastatic invasion of the viscera.

The progress of the disease comprises three periods. During the first stage the attention is called to the eye by a peculiar greyish yellow pupillary reflex similar to the reflex obtained from the eyes of certain animals. As this reflex becomes more marked the pupil becomes widely dilated and the vision declines.

The second stage comprises the period of high intra-ocular tension, which becomes so great as to dilate the ocular coats, the anterior chamber becomes shallow, the pupil excessively large and irregular, the sclero-corneal limbus is injected, and staphyloma of the sclerotic appear. Later, the cornea loses its transparency and becomes anesthetic, the aqueous humor becomes turbid, the iris is discolored and forms synechiæ, the lens become opaque and the conjunctiva congested. The sclerotic of infants being very elastic, the child does not usually suffer much pain during the stage of intra-ocular pressure, but later, when the brain becomes involved, the pain and reflex symptoms are as severe, as they are mild in the early stages.

The third stage comprises that after perforation of the globe and protrusion of the growth externally as an easily bleeding and fungating mass.

It is not always possible to trace the channel of communication by which the disease spreads to the brain. The head symptoms begin as a simple headache, shooting neuralgic pains, convulsions and paralysis of the face or limbs, and finally coma and death. When the optic nerve is invaded as far as the chiasm, blindness of the other eye ensues. The second eye may become involved from the glioma cells following the optic nerve to the chiasm and thence to the orbit.

To avoid an error in diagnosis every symptom must be taken into consideration. Cyclitis and purulent hyalo-retinitis of idiopathic or traumatic origin, detached retina, cysticercus, choroidal sarcoma, choroidal tuberculosis, etc., will be mistaken for glioma if great care is not observed. The age of the patient, previous history and general physical condition, whether he has suffered from cerebro-spinal meningitis, septicemia, typhus fever, etc., must be considered. In suppurative choroido-retinitis, the symptoms of inflammation come on early and the eye soon softens, while in glioma, the intra-ocular tension constantly increases until staphyloma is produced.

Cases of double retinal glioma are so rare as to be of interest. They are of interest to general practitioners on account of the fact that from the retinal growth other and distant organs become affected, either from direct extension or by metastasis. It is rare to see double retinal glioma without inter-current symptoms giving evidence of the appearance of the growth in other parts of the body. In both my cases the disease was seen in the eyes for some time before cerebral complication occurred.

CASE I. In 1885, N. L——, a strong, well nourished boy five years old was brought to my office for examination. Nearly a year previously a peculiar appearance of the eye was noticed. Both eyes were involved to about the same extent and he had been totally blind for three or four months. The cornea and lenses were clear, the pupils widely dilated, the intra-ocular tension markedly increased, and a yellowish gray reflex was noticed. By focal illumination and with the ophthalmoscope, the irregular surface of the growth could be seen with vessels passing over its surface. The eyes were free from inflammation and pain. Glioma was diagnosed, and the parents were informed that the only possibility of saving the child's life was by enucleating both eyes. Through my advice the parents also consulted a prominent San Francisco oculist, who coincided in this opinion. The parents, however, declined to have the effort made, and returned home to a distant part of the State, where the child died a few months later.

CASE II. November 7, 1894, I was called to see Mr. G——'s rugged-looking son, between one and two years old. The family physician was in attendance at the same time for nervous symptoms, which seemed to be the result of the appearance of three teeth at once. When this physician had attended the child about three months previously he noticed an unusual condition of the eye, and advised the mother to consult an oculist in regard to it. The mother said that she had not followed the doctor's advice through dread that there might be something seriously wrong with the infant's eye. At his last visit the doctor found the eye so much worse that he insisted upon an examination by an oculist. I found the left eye slightly congested, the cornea, aqueous, and lens clear, the pupil widely dilated, and the intra-ocular tension slightly increased. A yellowish grey reflex was obtained from the vitreous without the ophthalmoscope. With the ophthalmoscope the vitreous chamber was seen to be nearly filled with a growth over the uneven surface, of which the serpiginous course of the vessels was well marked. Vision in that eye was totally lost. On account of the very irritable condition of the child at my first visit it was deemed best to make another examination under more favorable conditions before giving an opinion. A few days later the child was found much more tractable, but unfortunately the growth had made rapid progress during that short time. The iris and lens were found pressed far forward, the cornea seemed stretched, and considerably opaque, and there was thinning and bulging of the sclerotic near the corneal border. At this visit cocain was instilled into the other eye and an ophthalmoscopic examination made. A small greyish deposit was found in the retina of that eye not far from the yellow spot. The child could still see ordinary playthings with that eye, but looked sidewise instead of directly at the object. This showed that the center of the visual field was less perfect than the edges. The father was informed that the child had malignant disease of both eyes, and that without a double enucleation the child would certainly die within a few months. I urged that the child be examined by another oculist, but the parents did not seem inclined to proceed further in the matter. I did not see the child again, and know nothing of its history until its death, which took place within four months after I first saw it.

In cases of single glioma, enucleation, at the earliest time that we can be reasonably certain of the nature of the disease, is imperative. In cases of double glioma there is, I think, room to doubt whether double enucleation should be urged or not. We should, even in this very hopeless condition, explain the nature of the disease and the prognosis, and give the parents the opportunity of having double enucleation performed, which might possibly save the child's life. Parents will rarely submit to having both the child's eyes removed. They will cling to the hope that a mistake has been made in the diagnosis; and if it is a question between the loss of both eyes or death, they choose the latter.

429 J street.

DIPHTHERIA AND INOCULATION.

By W. F. Lynch, M.D., Oakland, Cal.

Read before the Oakland Free Clinic Association.

The name diphtheria is of quite modern origin, yet the disease itself is as ancient almost as man himself. Accounts of its existence can be traced back more than 2,000 years. Probably the most concise description of ancient times was that of Hippocrates, some 400 years prior to the opening of the Christian era. Its virulence was so great and the disease so widespread that in the days of Celsus, who flourished in the reign of Augustus Cæsar, it was well recognized.

There is historical evidence indicating that the first succinct account of the disease and its treatment originated with Aretæus, who flourished in the latter part of the first and the early part of the second century, and whose writings still exist, almost complete, translated into various modern languages. Following Aretæus, scarcely any trace of the disease can be found in literature for nearly 500 years, or until the time of Paulus Ægineta, who wrote of it in the seventh century. Later, we find a description given by the Arabian school of writers; after which, until the sixteenth century we do not find any accounts of the disease, when its discussion was taken up by numerous writers in Holland, France and Spain, where it was very prevalent. From that period to the present time the whole civilized world has felt the ravages of diphtheria—extensive epidemics being noted in the seventeenth and eighteenth centuries, since when it has been widespread over the entire globe.

To Bretonneau we are indebted for the name and for a most searching inquiry within the last century. The description by Dr. Starr, in England, in 1749, in its clinical aspects is scarcely equaled by any writer in our language at the present time. In the United States, in the latter part of the last century, Dr. Samuel Bard was probably the first to give the disease any extended study.

While in its pathological aspects and clinical features diphtheria is now so well recognized, we have up to the present time most dismally failed to find any treatment that is satisfactory unless we except the new method of which I will speak presently. No disease has had wider ranges of method of treatment advocated or a greater number of remedies suggested, with such meager results to show.

Since the immortal Jenner, now almost 100 years ago, gave to the world vaccination, though researches in this direction as applied to other diseases have been more or less constantly occupying the attention of investigators, yet there was no real activity in this line developed until after the publication of Koch's elaborate and masterly studies in bacteriology, in 1882.

Though our knowledge of the presence of bacteria has assumed a degree of completeness only within the past ten or fifteen years, yet Leuwenhock, as far back as 1675, demonstrated the existence of bacteria. The natural result, we may say, of the discovery of the bacillus, is the study of the effect of attenuated cultures upon the animal organism; and these we will now consider.

Pasteur, in 1880, found that disease germs may be weakened by certain processes of culture, so that an attenuated virus may be procured and used by inoculation, producing a disease, the virulence of the symptoms depending upon the greater or less dilution of the cultures. He made a study of the bacillus of chicken-pox, and found that an innocuous cultivation could be procured that could be employed successfully for protection against this disease. His investigations also extended to experiments on the same line in anthrax and hydrophobia. By the inoculation of an attenuated virus of anthrax, he has been enabled to avert the immense destruction of sheep which has occured from this disease.

At later date, the whole civilized world was thrown into violent agitation by the results of investigations by Koch with tuberculin. Tuberculin, briefly stated, is "a glycerine extract of the cultures of the tubercle-bacillus, which was really an attempt to produce immunity by the chemic products of the bacilli;" and though inoculation for phthisis has not reached the high estate to which there was a profound hope it might, yet we may see good results later.

In 1885, we find inoculation of attenuated cholera virus receiving attention. In Barcelona, Dr. Ferran experimented in this disease upon 500 persons, with highly favorable results. And now we are awakened by the apparently beneficent results obtained by applying the principle in a modified form to the treatment of diphtheria.

By way of preface I may state, though blood serum-therapy may properly be said to have originated since 1891, yet history points a time far back in the past when the idea of immunity and serum-therapy seems to have flashed in the brain of one Mithridates, a hundred years before Christ, if we are to believe Pliny, who wrote in the first century of the present era.

Nuttall and others have shown that the normal blood serum seems to possess some germicidal power, but in what manner or by virtue of what element in the serum has not yet been positively ascertained. Certain substances found in the serum, having their source in the tissue cells and termed alexins, are thought to be the factors in rendering the animal immune, and theoretically those elements existing in sufficient quantity in the serum, which varies with the vital activity of the tissue cells, render the body insusceptible to infection. In his experiments, Nuttall found that the serum of animals rendered immune by previous inoculation with the antitoxine of anthrax had a greater germicidal power than normal blood serum.

To Behring and Roux, between whom the honor seems divided, is due the advancement of the idea that not only might immunity be established, but disease itself may be markedly controlled, and, in a large percentage of cases, cured by the inoculation of blood serum from an animal rendered artificially immune. Behring found this to be true in diphtheria some four years age; Kitasato reaching similar conclusions in tetanus. Loeffler was the first to demonstrate in the guinea pig that immunity from diphtheria could be obtained. Fränkel, Behring and others attempted to produce artificial immunity from diphtheria by various cultures; among these were sterilized bouillon-cultures, bouillon-cultures treated with iodin-trichlorid, and with "tissue juices of animals sick or dead with diphtheria, and also by feeding with toxines of the diphtheritic bacilli."

As you are all familiar with the methods of preparing the blood serum for therapeutical use, I shall dwell on the subject but briefly. To quote from an article in a recent medical journal, "The animal receives subcutaneously in the region of the shoulder a quantity of an old bouillon culture of diphtheritic bacilli which has been nearly freed from organisms by filtration, or simply by decantation; to this is added 5 per cent of carbolic acid. The mixture is well diluted with water, and sufficient is injected to set up a mild reaction, the temperature reaching 102.4° F., or a little more." Repeated inoculations are required, at intervals of two to four weeks, and covering a period of six months before the animal becomes immune.

In Behring's establishment there are something like 75 head of horses whose blood is utilized in the preparation of the serum; a corps of 50 trained men are employed, and at the present time about 2,000 doses per day can be prepared. The antitoxic strength of the blood serum is tested from time to time on smaller animals, usually the guinea pig; and when the desired strength is reached, the blood is drawn off through a canal into sterilized vessels, and cooled in ice boxes for 12 or 14 hours. After a firm clot is formed the serum is poured off and 5 per cent of carbolic acid added.

The test is simply to determine the activity of the blood serum of the smaller animal in resisting various degrees of strength of the toxine. As a result, a standard has been established in which 1 cc. contains 500 of the so-called imunizing units. It has been determined that about 500 units are required for the cure of diphtheria in children; but a little in excess of this is advised.

There are three forms in which the serum is dispensed—one of 500 units, one of 1,000 units, and one of 1,500 units. The first is to be employed when the case is seen in the first and second days; the second after the second day, or in cases where great virulence is manifested in the first and second days, or when the larynx has become involved; the third strength is employed in adults, or in protracted and severe cases in children. A serum representing 150 units has been used in children as a prophylactic measure, and should be repeated in two or three weeks, as immunity is lost when that time has elapsed.

Aronson's serum is about three times the strength of that used by Behring, the cultures that are injected into the horse having been previously treated with a current of oxygen, and in so doing the cultures are freed from other foreign substances, thereby giving greater potency to the serum, in the fact that larger doses of the cultures may be given to the animals.

Buchner, in an elaborate and interesting paper read before the eighth International Congress of Hygiene and Demography, has summed up certain conclusions upon which the investigations have been based, which, briefly stated, are as follows:

1. The so-called natural immunity to infectious diseases depends upon conditions distinctly different from artificially induced immunity.

2. Natural immunity depends (*a*) on the bactericidal action of certain substances, in solution, in the organism, of the so-called alexines; (*b*) on an inherent insusceptibility of the tissues and cells of the body to the several bacterial poisons. This cannot be transmitted from one body to another by means of the blood.

3. Leucocytes play an important part in bringing about immunity through the action of soluble substances secreted by them.

4. Artificial immunity depends upon the presence of modified specific bacterial products, the so-called antitoxines, either in the blood, the tissues, or in both, and can be transmitted.

The action of the antitoxines depends not upon the distinction of the bacterial poison by contact, but occurs only in the animal by rendering the tissue cells less susceptible to the destructive action of the bacteria, and the whole body thus becoming resistant.

The serum causes marked amelioration of the symptoms in a short time—24 hours or less. No ill effects of any serious moment have yet been noted, though some milder toxic effects have recently been reported in a limited number of cases. Enthusiastic advocates of the method advise the discontinuance of other treatment, but the more conservative continue it. A caution is given in regard to the use of bichloride of mercury, as this seems to neutralize the effect of the antitoxine.

The results obtained will be briefly stated by citing a few statistics. Reports from the Institute for Infectious Diseases in Berlin, show the mortality has been reduced to 16 per cent. When cases were seen as early as the first and second days none were fatal. All cases, it is held there, if seen sufficiently early, and if the remedy is used in sufficient quantity, should recover.

Mr. Ernest Hart, in England, reports 36 cases, with 2 deaths, using Aronson's serum. In the Buda Pest Hospital for children Prof. Bokai reports the following results from September 21 to October 22, when the serum became exhausted: 35 cases, with 5 fatal, a mortality of 14⅓ per cent. Of these 35 cases 63 per cent were very severe in character. From this hospital the following is quoted simply to compare results under former methods with that of serum-therapy: In 1891 the recoveries were 43.2 per cent; in 1892, 57.1 per cent; in 1893, 38.3 per cent; in 1894, 85.6 per cent, the last under serum-therapy.

From the Hospital for Diseases of Children in Paris, the following figures are given: In 1890, 88 per cent died; in 1891, 45 per cent; in 1892, 64 per cent; in 1893, 47 per cent. During the period of treatment by the serum in 1894 there were 448 cases admitted, of these 109 died, a mortality of 24.5 per cent. From the total number are deducted 128, who did not have true diphtheria, and 20 more who died before the treatment could be adopted, leaving 300 having true diphtheria, of these 78 dying, a mortality of 26 per cent. The researches prior to this show that of all those afflicted with true diphtheria, proved by accurate bacteriological examination, 50 per cent died.

To compare results, statistics are given from the Trousseau Hospital during the same period, when serum-therapy was not in use. From February to June there were admitted 520 cases, with 316 deaths, or 60 per cent. In operated cases under the use of serum-therapy the mortality was 49 per cent in the hospital from which Roux reports. In the Trousseau Hospital during the same period without its use the mortality of operated cases was 86 per cent.

We must certainly acknowledge that up to the present time, as far as figures are concerned, the results seem encouraging, but the treatment is new, and more time and experience must elapse before final judgment can be passed. Such high authorities as Virchow, Klein, and others are not willing to accept the matter as proven, and some are even inclined to attack the rationale of the treatment. Let us hope, however, that in serum-therapy we shall find a potent weapon with which to wage warfare against this dread scourge of the human race.

—— street.

MEMORANDA.

Nasal Polypi, with Affection of Maxillary Antrum and Sphenoidal Sinus.

The following case is of interest on account of the number of tumors and the extent of the accompanying disease. Mr. C. F. G——, aged 35, laborer, came to the clinic at Cooper Medical College January 7, 1895, complaining of a swollen face and inability to breathe through the nostrils. Has had more or less trouble with the nose for past fifteen years. When fourteen years old, the right nostril became stopped up and was then treated by a homeopath. Two years later a polypus was removed from that side and the following year the right side of the face became swollen and the nasal bones distorted. A Brooklyn physician diagnosed cancer of the antrum and recommended resection of the right superior maxilla. In three days a discharge of pus commenced from the right cheek, which continued for about three weeks. After this, patient was able to breathe through the nostril until two years ago, when it again became occluded. The secretion is, at present, excessive, white and of a frothy appearance. Taste is normal, but there is anosmia. Patient is a mouth-breather. *Examination:* The nasal bones are widely separated. The right cheek greatly swollen and the skin quite tense over the region of the antrum. The right nasal fossa is entirely occluded by tumors of a polypoid appearance and consistency. The left nasal cavity is also occluded by an extensive deflection of the septum, which is in contact with the external wall. The tongue is slightly coated; tonsils normal; uvula elongated; pharynx covered with tenacious secretion. Slight insufficiency of the right internal rectus. R. H. $=\frac{8}{18}$. L. H. $=\frac{1}{18}$. *Diagnosis:* Nasal polypi. Deflection of septum. Antrum disease. January 9th, five polypi were removed. January 16th, eleven large polypi and numerous small ones. January 23d, small polypi. Both turbinated bones were diseased and came away with the growths; numbering thirty-four in all. There was a large oval perforation into the antrum of Highmore, measuring eighteen millimeters long by eleven millimeters wide. The antrum gives evidence of former disease, but no denuded bone can now be detected. The ethmoidal cells were diseased and were curetted. On the posterior superior wall of the fossa, the nasal wall of the sphenoidal sinus presented a large irregular opening, measuring two centimeters in the vertical line and fourteen millimeters in the horizontal. A probe passed through this perforation touched the posterior wall of the sinus and measures, from the tip of the nose, nine and two-tenths centimeters. The extensive deflection of the septum produced a very spacious cavity, the measurements of which were as follows: Anteriorly, floor, 24 mm.; opposite mid. turb., 24 mm.; roof of fossa, 10 mm. Middle of right fossa, floor, 31 mm.; opposite mid. turb., 36 mm.; roof, 8 mm. Posteriorly, right fossa, floor, 21 mm.; opposite mid. turb., 21 mm., roof, 14 mm. Their still remains an extensive tenacious secretion and crust formation, but great relief was afforded the patient by entire removal of the growths. Although there is a negative specific history, the patient has been subjected to anti-syphilitic treatment and still remains under observation. The tumors, thirty-four in number, after being in alcohol two months, occupy 7.8953 cubic inches. WILBER M. SWETT, M.D.

San Francisco, Cal.

DEPARTMENTS.

OBSTETRICS, GYNECOLOGY AND PEDIATRICS.

By WALLACE A. BRIGGS, M.D., Sacramento, Cal.,
HENRY GIBBONS, JR., M.D., Professor of Obstetrics and Diseases of Women and Children, Cooper Medical College, San Francisco, Cal., and
WM. FITCH CHENEY, B.L., M.D., Adjunct to the Chair of Obstetrics and Diseases of Women and Children, Cooper Medical College, San Francisco, Cal.

Rapid Delivery for Eclampsia.—DR. J. CLIFTON EDGAR, of New York, has delivered a woman, whose os uteri had not yet begun to dilate, of twins, in just 29 minutes from the time of beginning instrumental dilatation. The case was one of eclampsia, at 8½ months. Edgar employed Dührssen's method of incising the cervix deeply as far as the vaginal junction. The woman and both children survived. The case is reported in detail, with two others, where the deep cervical incisions were made to expedite delivery.—*American Journal of Obstetrics*, June, 1895.

Trephining for Tubercular Meningitis.—B. MERRILL RICKETTS trephined a child for tubercular meningitis to relieve pressure symptoms. Two openings were made over the right and left parietal bones, and large quantities of serous fluid escaped. There was improvement immediately following the operation, but for a few hours only. The child died 28 hours after operation. The operative cure of tubercular peritonitis has been accomplished so many times that Ricketts thought it worth while to try it in tuberculous meningitis.—*International Medical Magazine.*

Tongue Tractions for Asphypia of the New Born.—The method recently proposed by LABORDE, of Paris, for resuscitation of asphyxiated infants seems to meet with general indorsement. It consists in seizing the tongue between the thumb and index finger, or with forceps, and drawing it out at regular intervals between tractions, letting it slip back. Numerous reports appear in the journals by those who have tried it, and all speak highly of its efficiency. Laborde explains the action of the method by its bringing about respiration through excitation of the superior laryngeal nerve.

Results of Symphyseotomy.—VON WAERZ reports ten symphyseotomies performed in Schauta's Clinic in Vienna, sometime previously, most of the patients being still available for observation. Of the 10, one died of sepsis after operation; 6 are in good condition, able to work without inconvenience; one could not be traced after leaving the hospital; one could not stoop to work on her hands and knees without pain in the sacro-iliac joints; one suffered from incontinence of urine, but was cured by taking cold baths. Eight cases are also reported from Gustav Braun's Clinic in Vienna, none of which died; 6 are now in good condition, working without inconvenience; one suffers from incontinence of urine and sacro-iliac pain on heavy lifting; one has incontinence of urine on straining and lifting. Drilling and wiring the symphysis have been practically abandoned as a part of the *technique;* the results are as good without it.

Latest Technique of Vaginal Fixation.—Since DUHRSSEN first suggested fixing the uterus to the anterior vaginal wall for backward displacement, the steps in the operation have been much modified. It has been found that attaching the organ by sutures passed at the hight of the internal os does not suffice, return of the displacement almost invariably occurring. In the effort to seize the uterus higher up the peritoneal cavity was accidentally opened by several operators, but in these cases the results were perfect. It has, therefore, been adopted as the proper plan of procedure, and opening the vesico-uterine *cul-de-sac* is now advised, so that the fundus can be seized with bullet forceps, pulled down and sutured to the vaginal wall. The operation thus becomes a vaginal celiotomy. WERTHEIM reports 37 cases, and concludes that in every instance of vaginal fixation the peritoneum must be opened to insure success.—*Centralblatt f. Gynäcologie*, May, 1895.

Methyl-blue for Malaria in Children.—FERRIER has used methyl-blue in the treatment of malaria in forty children with satisfactory results. The remedy was found useful in some cases in which quinine had failed. Unpleasant effects were never observed. Neither the stomach, bladder nor kidneys were disturbed in any way. From 0.5 to 9.5 grammes [7½ gr. to 2⅓ drachms] were administered daily. The amount given depended more upon the severity of the disease than upon the age of the patient. In order to prevent a relapse the drug should be continued several days after signs of the disease have disappeared. A convenient vehicle for its administration is syrup of orange or cinnamon. Under its use the general condition improves rapidly. *Jahrbüch f. Kinderheilkunde*, Bd. xviii, Hft. 1. [Methyl-blue is better known in this country as a stain for pathological tissues than as a drug for internal administration. So far as tried it is considered inferior to quinine in malaria. W. F. C.]

Sublimation of Calomel for Croup.—This is not a new idea, but recently much is being said in its favor by good authorities. Its special indication is laryngeal stenosis, as shown by stridulous breathing, hoarseness, or aphonia and lividity of the surface from deficient oxygenation of the blood. The child's bed is covered with a tent made with a sheet. Beneath this tent is then placed a calomel powder on a tin plate over an alcohol lamp. The vapor from the burning calomel is confined in the tent and thus inhaled by the child. The proper amount to use at one time is about 15 grains, the duration of inhalation should be 10 minutes, and the process is to be repeated every half hour to two or three hours, depending on the urgency of the case. J. HENRY FRUITNIGHT, of New York, highly indorses the method in the *Archives of Pediatrics* for June, 1895, and reports cases where calomel sublimation rendered intubation unnecessary. Ptyalism does not result. The *rationale* of the remedy is not satisfactorily explained.

Treatment of Empyema in Children.—EDMUND CAUTLEY, physician to the Belgrave Hospital for Children, London, reports in the *Archives of Pediatrics* for March, 1895, 84 cases of empyema observed during the course of ten years past. All were under 12 years of age, 57 under 6 years, but none under 1 year. Fourteen out of the 84 died—a mortality of 16.6 per cent. Four received no surgical treatment at all; 12 were treated by aspiration; 35 by incision and drainage; 33 by resection of a rib. From these cases Cautley draws the following conclusions: (1) An empyema may be reabsorbed, especially if the pneumococcus is the cause; but it is bad treatment to leave the case to nature, on account of the risk of rupture internally through the lung, or externally through the chest wall. (2) Aspiration is at best a temporary and unreliable mode of treatment; cases recover completely under it, but the risks are out of proportion to the advantages gained. (3) Simple incision and drainage is better than resection of a rib or part of a rib. It is very exceptional in children not to be able to drain efficiently through an intercostal space. Recovery does not appear to be more rapid under treatment by resection, and the shock is more severe. (4) When the medullary cavity of a rib is laid open, there is greater danger of pyemia. (5) The risk of hemorrhage is very small under either mode of treatment. (6) It is unnecessary to explore the cavity and break down adhesions, in some cases it may be distinctly injurious. (7) The chances of a radical cure are certainly no better under treatment by resection; and there is greater liability to imperfect expansion of the lung and contraction of the side in cases treated by aspiration or resection or left to nature, than if incision and drainage be adopted. (8) Resection should be reserved for the rare cases in which the ribs are closely approximated, or as a secondary means to insure closure of a sinus. (9) The drainage tube should not be more than two inches long; it is not necessary to insert a long tube, as the mode of cure is not by granulation from the bottom, but by expansion of the lung, ascent of the diaphragm and contraction of the side. It should be removed as soon as the discharge becomes scanty and serous, sometimes even as early as the third day, otherwise it acts as a source of irritation, keeping up the discharge, prolonging the illness and militating against a successful cure.

SURGERY AND ANATOMY.

By T. W. Huntington, B.A., M.D., Surgeon Southern Pacific Company's Hospital Sacramento, Cal.,

G. F. Shiels, M.D., C.M., F.R.C.S.E., Surgeon Post-Graduate Department University of California, San Francisco. and

Geo. B. Somers, M. D., San Francisco, Cal.

Whitehead's Operation for Hemorrhoids.—The following paragraph occurs in an article by Dr. M. Borts, of Cleveland, Ohio, (*Cleveland Medical Gazette*, February, 1895): "The last candidate for professional favor as an operative procedure, is known as Whitehead's operation. This is an ideal operation in certain cases. It is only indicated, however, where the entire, or nearly the entire, circumference of the pile-bearing portion of the rectum is involved. It is rather an heroic operation, and one not likely to be undertaken unless the operator has had considerable surgical training. It consists in making a circular incision just within the muco-cutaneous border entirely surrounding the anus; then, by a blunt dissection, dissecting up the entire mucous membrane, including the underlying vessels, and carrying the dissection far enough above the pile bearing portion, so that when traction is made, the healthy membrane may be brought down easily and stitched with fine sutures to the cutaneous border, after cutting off all the hemorrhoidal portion. The success of this operation depends entirely on getting primary union; and great care is needed to get this. If the mucous membrane brought down is put too much on the stretch, the sutures will tear out. If the wound was infected and suppuration take place, you will have an ulcerating surface entirely surrounding the anus; and when it heals by granulation, there is likely to be a stricture."

Prompt Aid to the Injured.—In the *Progrés Medical* for January 26, 1895, there is an editorial article by M. Marcel Baudouin in which he deals especially with the question of first aid to the injured. The discoveries, he says, which have revolutionized modern surgery are, at the present time, according to operators, three in number, and they may be classified as follows: (1) Anesthesia. (2) Temporary hemostasis. (3) Antisepsis and asepsis. Two of these discoveries, says the writer, are of unquestionable importance, and it may be said that without them the majority of large operations would never have taken place. Our estimate of temporary hemostasis as one of the wheels of progress during the last fifty years, appears to the writer higher than is just, but without the means at our disposal at the present time for temporary hemostasis, he says, many operations, particularly those directed against abdominal affections, would be impossible. To these three discoveries, the real importance of which is admitted by the majority of surgeons, M. Baudouin ventures to add another. He does this with the less hesitation, he says, since he is neither its father nor its sponsor. He has reference to the hospital ambulance service of New York, which he characterizes as an extension of Baron Larrey's flying ambulance service to meet the wants of the ordinary citizen. He thinks that immediate surgical aid to the injured is one of the most important boons that have been introduced into surgery during recent years, ranking with antisepsis. It is one of the principal factors of success in operative surgery, other things being equal, and it should at once be put on a par with the three discoveries that he mentioned at the outset. From a purely surgical point of view, it is even more valuable than the suppression of pain, anesthesia. It is time, says M. Baudouin, to organize in all the great industrial centers of Europe a service of prompt surgical aid to the injured, and to establish ambulances of great speed, for they are indispensable to such a service, if surgery is expected to make progress in the future.—*New York Medical Journal*, February 23, 1895.

Resection of the Rectum.—In an extensive article on this subject, DR. J. H. DUNN reaches the following conclusions: (1) Resections involving the middle or even lower part of the upper portion of the rectum give better after results than those in which the whole of the lower portion is excised, and need not give much, if any, greater mortality. (2) It is desirable to preserve as much of the lower portion as possible, and when the disease does not involve this part the floor of the pelvis ought not to be disturbed, or at most, not more than laid open behind by a single smooth incision. The excision should then invariably be made through an opening in the posterior wall of the pelvis, extending from opposite the third racial foramen to the tip of the coccyx. The latter bone is removed and more or less of the left border of the sacrum may be chiseled away or the sacro-sciatic ligaments divided close to the sacrum, as circumstances may require. (3) When it is necessary to sacrifice the pelvic floor on account of the low situation of the disease, this free posterior opening of the pelvis is usually necessary in securing free drainage and in order properly to loosen up and bring down the gut. (4) When the resection is entirely above the levator ani, very excellent voluntary control of the bowel may be preserved by this method. (5) In resections entirely above the attachments of the levator ani, various methods may be used in approximating the ends of the bowel and in securing drainage. Interrupted cat-gut sutures, or the Murphy button, may be used. The cavity in front of the sacrum is packed with iodoform gauze to obliterate all dead space for the collection of secretions. (6) When performed upon proper principles, and with experience and skill, and in appropriate cases, resection of the rectum is a useful procedure, without a great primary mortality, and often with excellent secondary functional results, and indeed, generally with fairly comfortable bowel control.—*Northwestern Lancet*, April 15, 1895.

Treatment of Fractured Patella.—Which is the best or most successful procedure to adopt in treatment of fractured patella, is a question which has been frequently discussed, but that still remains unsettled. The subject was discussed recently by the section on surgery of the College of Physicians of Philadelphia. DR. J. WILLIAM WHITE presented three cases in which brilliant results had followed Barker's operation. All of them were adult males, who had received simple transverse fractures of the patella. All were confined to bed only a few weeks; two had left the hospital and returned to work inside of two months, and one in eleven weeks from the time of injury. The method of Barker is to encircle the patella with a vertical antero-posterior silk ligature which, when tied, held the fragments firmly together. The operation is done subcutaneously, and the ends of the ligature are cut short. Barker uses a long needle, which enters the tissues below the patella and passes through the ligamentum patellæ into the joint, and being carried upward behind both fragments, emerges from the tissues above the upper fragment. A stout, twisted silk ligature is now threaded through the eye at the point of the needle and is carried downward behind the patella. The needle is then re-introduced into the lower opening and carried upward again, but this time in front of the patella; now being brought out at the uper opening, it is again threaded so as to carry the other end of the ligature down in front of the patella and out of the lower opening. The fragments are then approximated carefully and the ligature tied with a surgical knot, the ends cut off short, and antiseptic dressing applied. Professor White always makes a puncture with a knife so as to secure an opening through the tendon large enough to discharge clots of blood and serous fluid before introducing the needle, thus reducing tension and favoring early repair by drawing off the effusion from the joint. In the discussion that followed, PROF. JOHN ASHHURST said that no two fractures of the patella were alike, and treatment should, in a measure, be modified by the character of the injury. He preferred mechanical methods. He considered that the Jonathan Hutchinson's contention, that the separation of the fragments has for its sole cause the effusion into the joint, a just one. According to this, removal of the effusion by operation is important. DR. KEEN presented a case where it was impossible to approximate the fragments. He then chipped off the tubercle of the tibia, allowing the lower fragment to slide up. The patient recovered with a useful limb.—*Journal American Medical Association*, June 8, 1895.

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

By WM. ELLERY BRIGGS, M.D., Sacramento, Cal.

The Etiology and Treatment of Spasms of Accommodation.—DR. GEORGE F. SUKER enumerates the causes of spasms of the muscles of accommodation as follows: (1) One of the most frequent causes is working with minute objects, which can be seen distinctly only when brought closer to the eye than the normal *punctum proximum*. This is especially so when the work is carried on by scant illumination for any length of time. Hyperopic refraction calls forth an excessive employment of accommodation when glasses are not worn, or when the glasses are too weak. (2) Irritation of the ciliary muscles, especially of the ciliary nerves, often gives rise to various forms of spasm. The progressive form of myopia may be mentioned in this connection as producing spasm, also incipient glaucoma. (3) Insufficiency of the internal or external recti is another cause of spasm. (4) Various kinds of traumatism are very likely to produce spasm of the accommodation. Foreign bodies in the conjunctiva, or in the cornea, frequently maintain a spastic myosis due to reflex irritation. (5) Morphine and calabar bean are cited as specific causes of certain forms of spasm. (6) The effort to overcome diplopia may give rise to spasm of accommodation. This occurs more often when the diplopia is due to muscular insufficiency than when it is due to other defects. (7) Reflex spasm may sometimes be produced from several instillations of homatropine. This is of short duration, and may be overcome by the instillation of atropine sulphate. (8) Certain hyperesthetic conditions of the retina may bring about reflex spasm of accommodation. (9) Finally, inflammatory conditions of the conjunctiva, cornea, or sclera are capable at times of producing spasm. The rarer forms of spasm are attributed to epilepsy, hysteria, and disturbances of the central nervous system. Irritation of the cilio-spinal center may produce the same condition. The treatment of spasm of the accommodation is as follows: (1) If possible remove the cause. (2) Avoid continual strain of the eyes; advise frequent intervals of rest, if work cannot be entirely suspended. (3) Obtain the best possible illumination; ameliorate the too intense light by wearing smoked lenses. (4) Treat any insufficient muscle. (5) Correct any ametropia. It is not always necessary to correct the entire amount of hypermetropia. (6) In myopes, when spasm is produced by irritation of the ciliary muscles, it can be overcome by local leeching, and insisting upon absolute rest for the eyes. (7) The mainstay in the treatment is the sulphate of atropine, which is sure to allay the spasm as long as it is instilled, and in the majority of cases give a cure, provided the former exciting causes are done away with. (8) In traumatic cases make use of antiphogistic measures. (9) The constant galvanic current is much lauded in certain cases. Constitutional treatment should not be neglected.—*New York Medical Journal*, February 9, 1895.

DERMATOLOGY, SYPHILIS AND VENEREAL DISEASES.

By G. L. Simmons, Jr.. M.D., Sacramento, Cal.

Albuminuria After Etherization.—Dr. Barcusfeld (*Münch. med. Wochenschr.*) observed in 150 cases of narcosis from ether, four in which albuminuria occurred, either before or after the etherization. Of these four, but one showed albumin only after the narcosis without showing it previous to the etherization. This one was kept under observation, but no edema nor any outward symptoms developed.—*Schmidt's Jahrbücher*.

Thyroid Extract in Washerwoman's Eczema, and as a Local Application.—Menzies (*British Medical Journal*): A 42-year old washerwoman with acute impetiginous eczema of the hands was treated with the usual remedies without any relief. On the 6th of February she was given the thyroid extract; 24 hours later the skin began to peel. On the 12th of February the healing was well along; all the depression or little wound cavities had disappeared. It is also useful with lanolin in the treatment of serpiginous nodes, open buboes, chancres, and undermined skin swellings.—*Schmidt's Jahrbücher*.

The Limits and Value of Urethroscopy.—Caspar concludes an article on the above subject (*Annals des Malad. des Organes Genito-Urinaires*) as follows: (1) In regard to the utility and value of the urethroscope, the principle of external illumination is far superior to introducing a light into the urethra. (2) The urethroscope is, in many cases, of distinct diagnostic and therapeutic value, and cannot well be dispensed with. (3) Owing to anatomical and physiological reasons and the mechanical conditions which result therefrom, urethroscopy is kept within certain limits, beyond which the interpretation of the urethroscopic image becomes impossible. (4) Posterior urethroscopy for diagnosis and therapy is only justified in a small number of exceptional cases.

Exanthemata from Antipyrin Simulating the Roseola of Syphilis.—Dr. L. WICKHAM, of Paris, reports a case which came to Fournier's department of the Saint Louis Hospital with an exanthema, which Fournier and all that observed it declared at once to be a syphilitic roseola. The patient presented no other sign of the disease and denied energetically the possibility. It was found that the eruption had appeared after he had taken for two days two-gramme doses *per diem* of antipyrin. Fournier also mentions a case of exanthem from this drug which completely simulated measles, as it was accompanied by fever, lachrymation, conjunctivitis and coryza. Still there was no bronchitis, but frequent vesical tenesmus.—*Ann. de Dermatologique—Journal Cutaneous and Genito-urinary Diseases*, May, 1895.

Treatment of Psoriasis with Heavy Doses of Potassium Iodide.—In consequence of the recommendation of potassium iodide in the treatment of psoriasis by HASLUND, SIEFERT placed 13 patients of the Würzburger Julius Hospital on this treatment. Of these 7 were men and 6 were women. In one case the disease had existed since the first year of life; in another, the disease had first appeared in the thirteenth year; while in the remaining cases the disease had shown itself after puberty. Inheritance was proven in but two cases. Most of the cases had had repeated outbreaks of the disease. One case had noticeable constitutional disturbance at each outbreak. In another case the palms of the hands and soles of the feet were involved in the disease, as well as the rest of the body. Four cases were unquestionably cured through the action of potassium iodide; in one case, owing to disturbance of digestion, the potassium iodide could not be continued, although improvement was noted. Complete recovery in the remaining cases cannot be claimed, while the use of chrysarobin and anthrarobin lead to a quick cure. The amount of potassium iodide used varied from 344 to 850 grammes in the average treatment of seven weeks. That such great doses of iodide could be borne is accounted for by the fact that the remedy in large doses works as a diuretic, and hence is more quickly passed out of the system than is a smaller dose. Bad effects of the iodides are manifested in the snuffles, strong outpouring of tears, head pains, and disturbances of digestion. Edema of the larynx occurred in none of the cases. One of the cases showed, on markedly increasing the dose to 60 grains daily, a reddening of the soft palate with edema of the uvula. But one instance of the iodine eruption occurred—an urticaria-like outbreak. Increase of pulse rate was noted in all the cases on the day following an increase of the dose of the iodide. In six cases appearance of fever was observed, undoubtedly due to the action of the drug. The lighter grades of fever in iodism are undoubtedly overlooked, as there is little consitutional disturbance.—*Archiv. f. Dermatol. u. Syph.—Schmidt's Jahrbücher*, Bd. 245, 1895, No. 1.

MATERIA MEDICA AND THERAPEUTICS.

By WM. WATT KERR, M.A., M.B., C.M., Professor of Clinical Medicine, University of California, San Francisco.

Guaiacol Applications.—In the course of a discussion in the Société de Thérapeutique on the external application of guaiacol in pleuritic effusions and scarlatinal nephritis, M. MIRON S. SIGALEA, who was one of the originators of this method of treatment, stated that he had never observed any lowering of temperature rendering collapse imminent, as reported by some physicians. M. M. GRELLETY and FERRAUD, however, declared that caution was necessary, lest a collapsed condition be produced, at all events, in patients already very weak and low from the disease. On this subject, M. COTILLON'S warning as to the importance of using pure guaiacol, which has the property of being completely soluble in glycerine, should be useful. He remarked that whenever a non-crystalline guaiacol is employed, no certainty can be felt that it is pure.—*Lancet*, February 16, 1895.

The Effect of Serum Injections on Temperature and Pulse.—VARIOT has studied this question. All children under suspicion of diphtheria who are admitted to the Trousseau Hospital, receive, as soon as they come in, an injection of 20 ccm. of diphtheria antitoxin. This practice has given the author the opportunity of observing in children who do not develop diphtheria the physiological effects of the serum injections. His observations show that they cause a rise of temperature of from ½° to 1° C., and sometimes more. At the same time the heart's action is quickened and the pulse beat becomes more frequent. These phenomena are often followed by cardiac asthenia and arythmia of the pulse. Variot thinks it probable that this artificial febrile action plays a certain part in the process of cure, being analogous to the normal febrile reaction seen after serious but curable diphtherias before the serum came into use. Rendu pointed out that in three cases in which he had used the serum in adult patients, no rise of temperature followed the injections. Variot thought that the febrile reaction might have been overlooked in these cases, owing to the temperature not being taken with sufficient frequency.—*British Medical Journal*, March 30, 1895.

Treatment of Tubercle by External Applications of Guaiacol.—BUGNION and BERDEZ, with reference to the suprising results obtained by Bard, Courmont, Box and others, in the treatment of phthisis and even acute miliary tuberculosis with external applications of guaiacol, experimented on nine rabbits, as follows: Each received an intravenous injection of 1 cc., pure cultivation of tubercle bacilli; three were afterwards left without any treatment; three had 0.1 g. guaiacol (in almond oil), applied externally every day for three months; three had 0.2 g. guaiacol applied in the same way. The animals were all killed about fourteen days after the treatment had been discontinued. *Results and Conclusions:* (1) External applications of guaiacol lower the temperature in rabbits, as in man. (2) In rabbits, as in man, guaiacol is absorbed by the skin and excreted in the urine. (3) In rabbits, these applications have no influence upon the course of acute tuberculosis, for all the animals were affected with an acute miliary tuberculosis at exactly the same stage of development. In spite of this, the authors do not consider that the treatment ought to be abandoned in man, as the good results obtained may be explained in other ways; for example, by causing oxidation of the coagulable toxalbumins.—*British Medical Journal*, April 27, 1895.

The Treatment of Dysentery.—SURGEON-MAJOR S. T. AVETOON, First Baluch Battalion, L. I., sends the following communication: "I wish to bring to the notice of the profession a new treatment for acute dysentery. It is not original, but was obtained from a medical work in Persian. The following is a translation: Treatment for acute dysentery—Reduce cinnamon bark to a fine powder, take one and a half drachms, mix it with a little 'mullai' [the cream that gathers on the top of boiled milk after it has been allowed to cool and settle], and administer in the morning on an empty stomach. The patient will be cured. I have made a slight alteration in the above. The powdered cinnamon is given in drachm doses only, mixed with a few drops of water and made into a ball, which is given to the patient to eat, washed down with a mouthful or two of water. This quantity is repeated again in the evening, and so on morning and evening until a cure is effected. It is a little over two years since I started this method of treatment, and have cured about thirty cases of the disease. Often patients have been cured by only one or two doses of the drug, while my worst case was cured after five doses only, but a sixth was given to make quite sure. This method of treatment is vastly superior to the ordinary ipecacuanha treatment, in that the medicine is pleasant to take and causes no nausea or vomiting, and acts, if anything, quicker and better than ipecacuanha. If the drug were given in drachm and a half doses as recommended in the book, most probably cures would be effected more quickly, but my method has been quite quick enough. The earlier the treatment is begun the more rapid the cure."—*Lancet*, March 2, 1895.

MEDICINE AND PATHOLOGY.

By ALBERT ABRAMS, M.D., Professor of Pathology, Cooper Medical College, San Francisco.

Post-typhoid Suppuration.—SULTAN reports the case of an individual who, six years after an attack of typhoid fever, developed abscesses in the region of the right clavicle and lower ribs. The abscesses recurred every few months. An examination of the contents, by culture, demonstrated the presence of typhoid bacilli. These bacilli are accused of producing osteo-myelitis, as other forms of bacteria, especially the tubercle bacilli, were absent—*Deutsche med. Wochenschrift.*

Peptonuria After the Serum Treatment of Diphtheria.—DR. HECKEL, in seeking to explain the cause of peptonuria, refers to its etiology in general. Grainger Stewart examined 771 healthy individuals and found peptonuria to be present in only three instances. Peptonuria may be of pyogenic origin in those inflammatory conditions when the pus corpuscles are rapidly disintegrated with resorption of the disintegrated products. Enterogenic peptonuria occurs during inflammatory and ulcerative processes of the intestinal mucosa (typhoid, carcinoma), and finally the hematogenic form occurring in severe cases of scorbutus. The author believes that peptonuria occurring after the serum injections is not referable to any of the foregoing categories, but may be attributed to the excretion in the urine of the fibrin contained in the serum.—*Münchener med. Wochenschrift*, February 19, 1895.

A Modern Iodine Test for Amyloid.—The iodine test, as employed ordinarily, for detecting amyloid degeneration in tissue, although very reliable, is often obscured by the color assumed by normal tissue, especially when the amyloid patches are small. GALEOTTI modifies the conventional method as follows: Sections of the alcohol hardened tissues are thoroughly washed in water and then immersed for about 25 minutes in a 5 per cent. solution of iodide of potash. After removal from the latter, they are quickly washed in water, after which, they are transferred to chlorine water. The chlorine replaces the iodine in the salt, and the iodine is liberated, staining the amyloid patches a deep mahogany brown, while the tissues remain almost colorless. The sections are eventually washed in water and preserved in glycerine.—*Centralbl. f. Allg. Path. u. Path. Anat.*

A Contribution to the Study of Digestion.—PENZOLDT presents the follow-facts: (1) The time of the appearance of free hydrocholoric acid depends in health, with slight variation, on the quality and quantity of the food. The more albumin contained in a diet, the later does hydrochloric acid appear. The addition of a moderate amount of fluid to the meal (200 ccm.) accelerates the appearance of free acid. An experimental meal, consisting of 70 grammes of white bread and 200 ccm. of water will, in normal cases, one hour after ingestion, enable the physician to demonstrate the presence of free hydrochloric acid. (2) Uffelmann's test for lactic acid is without practical value, as it yields no evidence of diagnostic importance. (3) Soluble albuminoid bodies are rarely found during digestion, as they are at once absorbed. (4) Peptonization begins in the stomach as soon as the albumin is broken up by the gastric juice. (5) Sugar is rarely found after a diet rich in carbohydrates, as it is readily absorbed.—*Münchener med. Wochenschrift.*

A New Culture Medium for the Bacillus of Diphtheria and other Bacteria.—DR. M. A. BALL, describes the following method: The blood of an animal is collected in a sterilized jar or bottle. As soon afterwards as possible, sterilized test tubes are filled, one quarter full of the pure blood, before it has clotted, or of the colored fluid portion which has separated, if clotting has already begun. The tubes are then placed in a slanting position, in a water bath, and slowly heated until the water in the bath is boiling; the boiling should be continued for ten minutes or more, until the blood has coagulated and become solid. It then has a chocolate color and a moist appearing surface, upon which a stroke culture can be made. From a pure culture of diphtheria bacillus on agar, an abundant growth was visible on the blood coagulum in 15 hours. It was sufficient to diagnosticate in 10 hours. If the tubes are to be kept for any length of time, they can be sterilized 2 or 3 times, at a temperature of 85° C. without injuring the medium.—*Medical News.*

Angina Pectoris of Gastric Origin.—S. S. GROUZDEW specifies among the causes of true angina pectoris, sclerosis of the coronary arteries of the heart and of the aorta. It may also be toxic (tobacco), infectious, nervous or reflex in origin. He refers to angina pectoris of gastric origin as constituting the most frequent cause of the affection excluding sclerosis of the cardiac vessels. He cites eight cases in support of this observation, one of which may be mentioned: A male free from arterial changes suffered from habitual constipation and dyspeptic troubles. His anginal attacks disappeared as if by magic after spontaneous or induced emesis. Among the objective symptoms of gastric angina the conventional manifestations of true angina are mentioned. Two symptoms, however, are constant, viz: tenderness and swelling of the epigastric region. The treatment suggested is directed toward reëstablishing the enteric and gastric functions.—*Semaine Médicale*, January 9, 1895. [The author will please to observe that the symptomatic picture of his anginal affection tallies in the main with the affection recognized under the designation, "asthma dyspepticum."—A. A.]

Hepatitis in Warm Countries.—M. KARTULIS, of Alexandria, refers to the frequency of hepatitis in tropical countries, which is explained by the existence of specific agents, which are particularly inimical to the hepatic functions. Such agents beyond high temperature and climate, are malaria, dysentery, diverse parasites, regimen, and the abuse of alcohol. The hepatitis observed in

Egypt, he divides into acute and chronic. The acute hepatitis is ordinarily produced by some error in diet, alcoholism, malaria, catching cold, dysentery, or by parasites (the echinococcus, ascarides and distoma.) Hepatitis caused by indiscretion in diet or alcoholism, often terminates in abscess. Malarial hepatitis yields to quinine, although it may likewise end in abscess. Acute hepatitis is frequently accompanied by catarrhal icterus. In Egypt, he has never observed grave icterus, acute yellow atrophy of the liver, or hemoglobinuric biliary fever to accompany hepatitis. Chronic hepatitis, he divides into three forms: (1) Chronic hepatitis which manifests by augmentation of the volume of the liver and extreme sensitiveness of that organ. It is most frequently caused by an abuse of alcohol. (2) Chronic malarial hepatitis characterized by enormous enlargement of the liver and spleen, absence of pain, fever and pronounced anemia. The effects of quinine must also be taken into consideration in the diagnosis. (3) Bilharzic hepatitis, which is characterized by the ova of the bilharzia in the urine. The bilharzia in the liver causes an anatomical condition analogous to hypertrophic cirrhosis rarely to atrophic cirrhosis.—*Semaine Médicale.*

Medical Septicemia.—PROF. W. S. CHRISTOPHER mentions numerous febrile processes met with, clinically, which cannot be referred positively to any known source. Such processes are found much oftener in children than in adults, and it is consequently in this field of work that the anomalous fevers may be studied to the best advantage. The laboratory is constantly making additions to the already long list of pathogenetic microörganisms, and the conclusion cannot be avoided that this list is as yet very far from complete. Considering together these two evidences, the clinical and the experimental, it is probably not too much to assert that there yet remains a great group of undifferentiated fevers—undifferentiated because upon the one hand their specific causes are unknown, and upon the other hand because they present no striking clinical peculiarities which would serve to classify them. Accepting the tendency of modern medical thought, it may be assumed as a fundamental proposition that there are many microörganisms which are capable, under suitable conditions, of initiating and maintaining distinct febrile processes—that is to say, processes characterized by elevation of temperature, interference with the functions of various organs (especially the brain, heart, lungs, and kidneys), and in some instances structural changes in various tissues and organs. The general category here indicated is sufficiently comprehensive to include such well known fevers as the exanthemata, influenza, croupous pneumonia, etc.; but besides these there are many others which cannot be made to fit into any of the special classes without unwise extension of definitions or undue violence to diagnostic honesty. It is proper to include these anomalous, undifferentiated fevers under some generic term, and he suggests "medical septicemia," Numerous advantages arise from recognizing under some generic term the febrile processes which are as yet undifferentiated clinically. It avoids forcibly classifying under specific names, processes having more or less resemblance to those of the name adopted. Specific processes have a more or less well marked natural history, and this being known, aids materially in prognosis and management. Undifferentiated processes doubtless have an equally well marked natural history, but this being unknown, adds materially to the difficulties of both prognosis and management. Another advantage of great value, clinically, is the assistance afforded in the recognition of mixed infections; this is particularly of service in diphtheria and scarlet fever, both of which are so commonly complicated by additional infections.—*Medicine*, April, 1895. [WUNDERLICH has already suggested the name of spontaneous pyemia to specify the affections described by Prof. Christopher. A still better term and one that has at least the approval of usage, is "cryptogenetic septico-pyemia." The latter term was introduced by Leube, in 1878, and included all septic affections without demonstrable traumatic infection. The hyphenated term septico-pyemia is indicated as descriptive of an infectious disease which may be associated with multiple purulent metastases. The etiology of this affection so thoroughly elaborated by Leube, is related to suppurating bronchial and mesenteric glands, old abcesses in the vicera, residua of puerperal and perityphlitic processes, etc. The genesis of the sepsis is usually determined at the *post-mortem* examination.—A. A.]

MENTAL DISEASES AND MEDICAL JURISPRUDENCE.

By A. W. HOISHOLT, M.D., Assistant Physician, State Asylum for Insane, Stockton, Cal.

Strophanthus in Dipsomania.—DR. M. A. SKWORZOW reports a remarkable effect of this drug upon cases of dipsomania. The observation was made on three patients in whom the attack lasted three to six weeks. After the first administration of strophanthus in 7 minim doses the attack was immediately cut short after the third dose. At first the patient experiences nausea and a wish to vomit without being able. Two or three minutes later a febrile reaction comes on, which is terminated by copious sweating. These unpleasant symptoms quickly disappear, and with them the longing for alcohol; its sight even provokes intense disgust. To cut short the attack in this way is not attended with any nervous symptoms. The author confesses himself unable to give any explanation of the result, and recommends further investigation.—*Journal de Médicine de Paris—Practitioner*, January, 1895.

Uremic Insanity following Traumatic Stricture of the Urethra.—CULLURE reports a case in which the retention of urinary products appears to have caused insanity. The patient presented symptoms of uremic poisoning in consequence of a traumatic urethral stricture, the general disturbances of which appeared to have produced the mental deviation. The patient had high fever, dry tongue, clay-like complexion, and complete anorexia. The mental symptoms were those of an acute melancholia, with hallucinations and morbid impulses. Predisposing causes of the insanity were, however, present; there was a neuropathic family history, and the patient had in the past committed alcoholic excesses. With improvement in the general condition, brought about by appropriate surgical and medical procedures, there was also a parallel change for the better in the mental condition.—*Archives de Neurologie—Journal of Nervous and Mental Disease*, December, 1894.

The Living-dead.—One of the most peculiar cases of catalepsy is "the living-dead," in Origny, Sainte Benôite, in France. The case is that of a woman, 30 years old, whose parents and sisters are hysterical. Her condition developed suddenly after a great fright. She had been suspected by her neighbors of having killed her child, which had been found dead, the labor having been of short duration, and the attention of the police had been called to these facts. As a result *gendarmes* were sent to arrest her; on seeing them approach her she became so affected that she fell to the ground and slept. From that day till now she has slept without interruption—in all about ten years. In the beginning of this condition a number of celebrated neurologists, among them Charcot, examined her, but failed to wake her. A physician, who claimed to have seen a similar case, said that on the day when she should awake she would die. Since then her family has not sought the advice of other physicians, especially as she has become a source of considerable revenue to them. She lies prostrate on an iron-bed, and resembles, though extremely emaciated, a healthy person sleeping a natural sleep. The eyes are partly open, exposing some of the sclera. The jaws are locked so tightly that it is impossible to separate them without using considerable force. The cardiac movements are regular, and the sounds audible, though feeble. All the other functions are normal. She is nourished through a stomach-tube and by means of enemata of peptones.—*Archives de Neurologie—Hospitalstidende.*

Clinical Forms of Mental Troubles following Acute Diseases.—At the last congress of the French Alienists, DRS. RÉGIS and CHEVALIER-LAVAURE brought up the subject of insanities connected with various infectious diseases, and said that they were now generally regarded as the result of intoxication. They usually take the form of what the Germans call "Verwirrsheit," and which Charlin so well described in France as "confusion mentale primitive." This opinion appears to have been accepted unanimously and supported by various eminent authors. The disease occurs more frequently in women at the age of 20 to 40 years. Rachitis and all weakening diseases of childhood seem to be predisposing factors. Heredity is, however, scarcely to be considered. Among causes we find excesses, febrile infections, diseases and auto-intoxications of all kinds, confinements, lactation, traumatic and mental shocks, operations, etc. All the authors agree that the disease is the consequence of cerebral exhaustion. Primitive mental confusion is defined as an acute or chronic functional disease of the brain, beginning generally with an acute hallucinatory stage, which is characterized subsequently by mental confusion, incoherent delirium, restlessness without apparent cause, alternating with intercurrent conditions of excitement and stupor. During the periods of quietness there are hallucinations and delusions, which are still more striking during the paroxysms, in which the patients are sometimes sad, excited, anxious or angry. The paroxysms of excitement may resemble those of melancholia agitata, mania acuta or agitated delirium. They generally change rapidly and immediately into a stage of stupor. During the periods of quietness the mental faculties are weakened and the speech is often incomprehensible and incoherent. The onset of the disease is generally sudden, and its course may be continuous, remittent or paroxysmatic, but is oftener an irregular combination of the different stages. The duration varies from a few days to several months, or even years. In regard to the pathology, anemic conditions of the brain and cerebral edema with meningeal troubles, have been described, which would seem to make primitive mental confusion an intermediate form of insanity between the purely functional and those with an anatomical basis. The symptoms of the disease resemble closely those of different forms of toxication, as alcoholism, saturnism, and rheumatic, cardiac and Brightic insanity. Most authors differentiate between the disease just described and a simple mental confusion without hallucinations; but a third type might be admitted, which may occur at any period of the infectious disease, but especially during convalescence, manifesting itself in light cases by delirium of grandeur and some somatic signs, in severer cases by the symptoms of dementia paralytica, which may disappear rapidly or become progressive. It will be observed that there is a tendency to consider the last named malady (dementia paralytica) as depending upon a toxic influence, viz: the toxines produced by the microbes of syphilis.—*Mercredi Medical—Journal of Nervous and Mental Diseases.*

Concerning Pyromania.—DR. CAMUSET reports the following interesting case. In October 1889, a certain man set fire to a barn, and on July 14th and July 21st, 1892, to flour mills. In each case the circumstances were identical; the fires occurred in the evening. He had committed the crimes unassisted; was the first one to give the alarm of fire and was one of the most active in trying to extinguish it. The motive for the first incendiarism was envy of the owner's wealth; in the two other cases the motive was a feeling of mortification on account of undeserved suspicion and teasing on the part of the owner's of the property. The family history of the person shows heredity on the mother's side. She had committed suicide and several in her family had done the same, and some were insane. The accused is mentally weak; had been from childhood irritable, malicious, jealous, ethically defective and had shown criminal propensities. He was, however, diligent and faithful at his work and not addicted to liquor. He presents mild manifestations of degeneration about the skull and ears; is very excitable; is easily moved to tears; finds the retention in the asylum very trying. It was shown that he belonged to the group of the intellectually and morally defective incendiaries, evidently on the basis of hereditary degeneration. He was sentenced to imprisonment for two years. Camuset shows how much these morally and intellectually degenerative existencies resemble the "born criminals" of Lombroso and finds only differences of degree between the two.—*Annal médico-psychologiques—Allg. Zeitschr, f. Psychiatrie*, Vol. 51, No. 6.

FORMULÆ.

Influenza.—Antipyrin still remains one of the most pleasant and rapid remedies for obtaining relief from the symptoms of influenza. By using the following, except where there are contraindications, relief is speedily secured:

Antipyrinæ	gr. v
Sodæ bicarb.	gr. v
Spr. ammon. aromat.	mx
Elix. simpl.	ʒss
Tinct. opii	mii
Aq. anethi	*ad* ℥ss

M. ft. Dosis.

S.—One tablespoonful every half hour for three doses, then every two hours, every three hours, and afterward every four hours, if required.—*Practitioner.*

Insect Stings.—A paint in which ammonia is kept in close and prolonged contact with the affected part is as follows:

Aq. ammoniæ	mcl
Collodion	ml
Ac. salicyl.	gr. v

S.—A few drops to be applied to each bite or sting.—*Medical and Surgical Reporter.*

Codliver Oil Tonic.—T. ROBINSON:

Extract of malt	℥iss
Pancreatized codliver oil,	℥i
Spirit of chloroform	ʒi
Oil cinnamon	M vi
Water	to ℥vi

S.—Teaspoonful 3 times a day after meals.—*Lancet— Universal Medical Journal.*

Gonorrhea.—The following is given by CARLESS, of King's College Hospital, as one of the best injections for neglected and chronic cases:

Zinc sulphate	gr. iii
Tincture catechu	Mx
Tincture opium	Mv
Glycerin	Mxv
Water	to ℥i

S.—Introduce about one-half of this mixture into the urethra, allowing it to remain about one minute, then letting it flow away.—*Universal Medical Journal.*

To Allay the Itching in Urticaria.—

Hydrarg. perchlor.	gr. iss
Chloroformi	M xx
Glycerini	℥ii
Aq. ros.	*ad.* ʒviii

S.—To be dabbed on the affected parts.—*Medical Press — Therapeutic Gazette.*

Vomiting of Pregnancy.

Menthol	gr. xl
Olei amygdalæ	ʒiii

Solve: Six to ten drops on a lump of sugar.—*Practitioner.*

PUBLIC HEALTH.

By W. R. CLUNESS, M.A., M.D., San Francisco, Cal.

Mortality for May, 1895.—The deaths registered in 65 town districts of the State, during the month of May, in a population of 746,923, correspond to an annual rate of 14.16 a thousand, the total mortality having been 887. 54 deaths were due to zymotic diseases, giving an annual rate of .86 a thousand. Of these, 6 were due to diphtheria, 9 to cholera infantum, 13 to typhoid fever, 6 to diarrhea and dysentery, 11 to cerebro-spinal fever, 4 to whooping cough, 3 to croup, 1 to intermittent and remittent fevers, 0 to scarlet fever, 1 to measles, and 0 to small-pox. 269 deaths resulted from diseases of the respiratory organs, giving an annual rate of 4.32 a thousand. Of these, 183 were due to consumption, 52 to pneumonia, 28 to bronchitis, and 6 to pulmonary congestion; the rate being, for consumption and pneumonia, 2.88 and .72, respectively. 84 deaths resulted from diseases of the heart, 3 from alcoholism, 3 from erysipelas, 29 from cancer, and 386 from causes not given. The average annual death rate from all causes occurring in the ten largest cities and towns in the State, and representing a population of 588,000, was 14.16. The highest rate for the month occurring in cities having a population of 10,000 or more inhabitants, was reported from San Francisco, the lowest from Fresno.

METEOROLOGY.

Summary for May.—*Temperature.*—The normal temperature of the State for May is 64.1°; the average for May, 1895, was 63.9°, a departure from normal of - 0.2°. The highest monthly mean was 95.8°, at Palm Springs; the lowest, 44°, at Cisco. The maximum temperature was 116°, at Salton and Volcano Springs, on the 8th. The minimum, 15°, at Bodie, on the 29th. The greatest monthly range was 68°, at Barstow; the least, 26°, at Eureka. The absolute monthly range for the State was 103°.

Rainfall.—The normal precipitation for the State for May is 0.89 inches; the average for May, 1895, was 1.40 inches, a departure from the normal of +0.13 of an inch. The greatest monthly precipitation was 8.55 inches, at La Porte. The least, nothing, at numerous places throughout the State.

Wind.—The prevailing direction of wind was W.NW.

Unusual Features.—There was no unusual meteorological feature for the month of May.—JAMES A. BARWICK, Director California Weather Service.

California—Tabular Statement for May, 1895.

STATIONS.		TEMPERATURE.						RAINFALL.		Mean Relative Humidity	WEATHER.			WIND.	FURNISHED BY—
		Mean	Highest	Lowest	Mean Highest	Mean Lowest	Mean Daily Range	No of Days Rain Fell	Total Rainfall		No. of Clear Days	No. of Fair Days	No. of Cloudy Days	Prevailing Direction.	
Auburn	Cal.	62.9	89	45.0	------	------	------	----	1.88	------	----	----	----	N.W.	Southern Pacific Company.
Berkeley	“	57.2	89	44.0	69.0	51.0	18.0	3	1.06	81.0	20	5	6	S.	Obs. University of California.
Colfax	“	60.5	86	42.0	------	------	------	----	4.80	------	----	----	----	S.E.	Southern Pacific Company.
Coronado	“	64.5	80	56.0	70.0	59.0	11.0	2	0.19	77.0	14	11	6	W.	Hotel del Coronado.
Eureka	“	53.0	68	42.0	58.0	48.0	10.0	13	5.39	83.0	9	12	9	N.W.	Weather Bureau Dept. Agr.
Fresno	“	67.0	98	45.0	82.0	53.0	29.0	2	0.52	49.0	23	3	6	N.W.	“ “ “
Independence	“	66.0	89	37.0	79.0	52.0	27.0	1	0.01	21.0	15	8	8	N.W.	“ “ “
Los Angeles	“	64.0	88	47.0	74.0	53.0	21.0	4	0.19	60.0	9	19	3	W.	“ “ “
Monterey	“	58.7	88	46.0	------	------	------	----	0.58	------	----	----	----	W.	Southern Pacific Company.
Napa	“	62.5	89	44.0	74.0	51.0	23.0	5	0.85	71.0	19	6	6	S.W.	Station Napa Insane Asylum.
Oakland	“	59.0	87	46.0	69.0	50.0	19.0	6	1.12	76.0	18	7	6	W.	Chabot Observatory.
Paso Robles	“	61.0	94	36.0	78.0	45.0	33.0	----	0.08	55.0	25	2	4	N.	Southern Pacific Company.
Red Bluff	“	66.0	98	47.0	78.0	45.0	33.0	6	1.65	54.0	20	3	8	S.E.	Weather Bureau Dept. Agr.
Sacramento	“	64.0	94	46.0	74.0	53.0	21.0	4	0.51	64.0	18	11	2	S.W.	“ “ “
San Bernardino	“	66.0	95	42.0	80.0	53.0	27.0	1	0.44	72.0	17	11	3	W.	A. K. Johnson, M. D
San Diego	“	62.0	80	51.0	67.0	56.0	11.0	2	0.19	77.0	14	11	6	W.	Weather Bureau Dept. Agr.
San Francisco	“	58.0	89	48.0	64.0	51.0	13.0	6	0.60	79.0	19	9	3	W.	“ “ “
Santa Barbara	“	60.5	81	46.0	68.0	53.0	15.0	2	0.02	72.0	17	6	8	S.E.	Hugh D. Vail.
Santa Cruz	“	61.0	92	40.0	74.0	48.0	26.0	3	1.15	------	23	3	5	W.	W. R. Springer.
Yuma	A. T.	79.2	109	54.0	95.0	64.0	31.0	0	0.00	33.0	27	4	0	S.W.	Weather Bureau Dept. Agr.

Blank (----) indicates data missing.

Occidental Medical Times.

COMMUNICATIONS are invited from all parts of the world. When necessary to elucidate the text, illustrations will be furnished without cost to the author.

SACRAMENTO: JULY, 1895.

CREMATION IN SAN FRANCISCO.

The advantages of cremation over earth burial, as a means of disposal of the dead, are so obvious to the medical mind that it is unnecessary to allude to them here. But while the profession is almost unanimously in favor of cremation, there yet remains a large proportion of the laity who, if not opposed outright, are at least indifferent to it. We are, therefore, pleased to note that a new crematory has been opened in the Odd Fellows' Cemetery, San Francisco. In less than two weeks fifteen incinerations have taken place, all of which have proved highly satisfactory from a scientific point of view. The furnace and flue have behaved admirably, engendering a heat of more than 2,000° Fahr. There has been a noticeable absence of smoke, and odor of any kind resulting from the cremation has been entirely imperceptible.

It is not, however, in these particulars that cremation has any advances to make, but there is room for improvement in the nice adjustment of a perfected process with dignified accessories of sentiment and ceremonial. Cremation in the abstract easily adapts itself to a poetic and religious setting, as Sir Henry Thompson well suggests in *The Contemporary Review:* "In order to meet a possible objection to the substitution of cremation for burial, let me observe that the former is equally susceptible with the latter of association with religious funeral rites, if not more so. Never could the solemn and touching words 'ashes to ashes, dust to dust,' be more appropriately uttered than over a body about to be consigned to the furnace; while, with a view to metaphor, the dissipation of almost the whole body in the atmosphere, in the ethereal form of gaseous matter, is far more suggestive of another and a brighter life than the consignment of the body to the abhorred prison of the tomb."

The builders of the new crematory have spared neither pains nor money to give to cremation that setting that a serious and a sentimental public requires. The building is an architectural gem, and is nowhere suggestive of retorts, furnaces or flues. The square and massive chimney looks far more like a monument to some hero than a flue to a furnace. The structure suggests both beauty and repose. There is an approach of steps cut in stone flanked by monumental pedestals carrying ornamental vases. One enters through a semicircular vestibule, inlaid with variegated marbles and floored with mosaic. The interior of the chapel is an ingenious compromise in the matter of style, evidently designed to be in harmony with all possible shades of religious feeling. The average churchman will find all that he desires to make a funeral service solemn and impressive. There is a handsome catafalque with silver railing and purple pall; lectern for ministers; organ loft for a choir; oaken pews for the mourners; deep pile carpets to subdue all noise, and stained glass windows to mellow the light. But perhaps far more than all this, bereaved ones will be grateful for the manner in which the casket, while yet the last rites are in progress, no one knows exactly when, is silently and invisibly lowered by attendants on the floor beneath, and borne away to the incinerating chamber—the pall-covered catafalque still remaining in the center of the chapel. When the friends disperse, the obsequies are at an end, as surely as when the coffin has been lowered into the grave and covered over.

In the near future, when, as Professor David Starr Jordan says, "our civilization will take cremation as a matter of course," people will not think of following the remains of their dead into the furnace room during the few hours of incineration any more than they now think of revisiting a vault from year to year to inspect the interior of the coffin.

THE COMMENCEMENTS—COLLEGE OF DENTISTRY.

The commencement exercises of the College of Dentistry, University of California, were held at Odd Fellows' Hall, Thursday evening, June 13th. Dr. W. C. Reith, of Sacramento, delivered the address on behalf of the faculty. This was followed by the conferring of the degree of Doctor of Dental Surgery, by Prof. Martin Kellogg, President of the University. During the evening music was furnished by Blanchard's orchestra. The following are the names of the graduates:

William Amos Atwood, Frederick Richard Axton, Thomas Francis Barrett, B. S.; Herbert Andrew Bernard, John Nicholas Borger, John Bennett Bowles, James Albert Brown, Louis Etienne Brun, B. S.; Byron Leonard Carpenter, Ralph Charles Coleman, David

Milton Coney, Eugene Morris Dodson, Oscar Plank Fitch, James Garrett Fitzgibbon, Arthur Morris Flood, Arthur James Ford, Reuben Lyon Hale, Eminel Potter Halsted, John Ross Hardy, Charles Peter Hauselt, Edward Shortridge Holloway, Joseph Arthur Jeffery, William Berridge Ludlow, Jr., Francis Ashbury McCan, Amiel Morris, Robert Emmett O'Connell, Clarence Hubert Pearce, Robert Henry Porterfield, Frederick Earl Sawyer, Leo Sichel, Walter Emery Singleton, Robert Washington Smith, Harley Howard Stephenson, Edward Lord Strain, Arthur Livingston Tibbetts, Newton Booth Wachhorst, Edwin Ruthven Waterman, Frederick Heilbron White.

The total number of students in attendance during the past session was 168, the number of matriculates being 63.

NOTES.

Mississippi Valley Medical Association.

The 21st annual meeting of the Mississippi Valley Medical Association will be held in Detroit, September 3d to 6th, 1895. A preliminary circular has been issued by the secretary, Dr. F. C. Woodburn, of Indianapolis, stating that the attendance will probably be quite large. September is an excellent time in which to visit Detroit, and the local profession has promised to look after matters, socially, in a liberal spirit.

Medicine.

This is the title of a new medical journal of medicine and surgery, published by Geo. S. Davis, of Detroit, Mich., with Dr. Harold Moyer, of Chicago, as editor. This is, no doubt, to take the place of the *American Lancet*, the publication of which was recently suspended. The initial number of the journal contains six original articles. Amongst the author's names we notice Dr. H. A. Hare, of Philadelphia, and Dr. G. Frank Lydson, of Chicago. The progress of medical science contains the usual reviews of current literature. The various departments include medicine, therapeutics, pathology, bacteriology, neurology, psychiatry, dermatology, laryngology, ophthalmology, gynecology and obstetrics. Amongst the names of those in charge, we note that of Dr. N. S. Davis, Jr., who will look after therapeutics. There is no editorial department; the make-up containing only original matter, book reviews and medical progress. The journal is clearly printed on good paper and contains 64 pages of reading matter; the subscription price is $2 per annum.

Alumni Association Medical Department University of California.

The Alumni Association of the Medical Department of the University of California, met June 26, 1895, at the hall of the Dental College, Donohoe building, San Francisco. After a brief address by the president, Dr. Washington Dodge, stating the objects and purposes of the reörganization of the association, several papers were read and discussed. Dr. Barbat read an instructive paper on appendicitis, in which he advised early surgical interference. The paper was discussed at length by Drs. Williamson, Mayer and McMurdo, with notes on special cases by Drs. Dodge and Blake. Dr. D'Ancona gave some very interesting stereoptican views of the brain and nervous centers. Dr. O. J. Mayer read parts of a very carefully prepared paper on the use of massage in uterine complications. Owing to the lateness of the hour, no discussion followed. The question of the time of the next annual meeting was discussed. It was decided that a banquet be given the graduating class of '95. A committee of three, consisting of Drs. D'Ancona, Barbat and McMurdo, was appointed, with full power to act in the matter. The association adjourned for light refreshments. There was a large attendance and much interest was manifested in the proceedings of the meeting. Dr. L. M. F. Wanzer. of San Francisco, is the secretary of the association.

International Congress of Dermatology.

The third International Congress of Dermatology will be held in London, August 4th to 8th, 1896. The following is a partial list of the officers; in several of the foreign countries there are a number of vice-presidents: President, Jonathan Hutchinson; Vice-Presidents, British, the President of the Royal Colleges of Physicians of London and Ireland and of the Royal College of Surgeons, England, the Directors-General, Medical Departments, Army and Navy, and a number of distinguished medical men. Of the United States: Dr. Duhring, Philadelphia; Dr. White, Boston; Dr. Nevins Hyde, Chicago; Dr. Bulkley, Dr. Keyes and Dr. Fox, New York; Canada, Dr. F. Shepherd, Montreal; Dr. Graham, Toronto. Treasurer, Mr. Malcolm Morris, London; Secretary-General, Dr. J. J. Pringle, 23 Lower Seymour St., London, W.; Secretary for the United States, Geo. Thos. Jackson, New York; Committees, Reception, chairman, Dr. Radcliffe Crocker; Museum and Demonstration, Dr. Stephen Mackenzie: Bacteriological, Dr. Sims Woodhead.

The following are the regulations: (1) All duly qualified medical men, British or foreign, or others interested in science invited by the counsel, who shall have paid the fee of £1, and who shall have enrolled themselves, shall be members of the congress and entitled to the volume of transactions. (2) The official languages of the congress shall be English, French and German, but with permission of the president, members may express themselves in the language with which they are most familiar. (3) The proceedings of the congress shall be embodied in a volume of transactions, edited by the executive council. (4) Communications relative to membership, papers, or other matters connected with the congress, should be addressed to the secretary-general, or to one of the foreign secretaries. (5) The fee for membership shall be payable in London, at or before the opening of the congress. (6) Members who are unable to attend the congress shall receive the volume of transactions. (7) The subjects treated of shall be of two orders: (*a*) Those selected beforehand by the executive council and introduced by gentlemen chosen for that purpose by the council. (*b*) Those selected by individual members themselves. (8) Subjects selected for debate by the council shall take precedence over those selected by the members. (9) The sittings of the congress shall take place from 11 to 1 in the forenoon, and from 3 to 5 in the afternoon, of each day. (10) There shall be clinical demonstrations of patients every morning from 9 to half-past 10, and every afternoon from 2 to 3. (11) Members contributing papers must submit an abstract of them to the secretary-general on or before the 1st of May, 1896, which will be printed either in full or in part, and embodied in the general programme of the congress, which will be distributed at its opening. (12) At every debate precedence will be given to gentlemen who have communicated beforehand their intention to take part in it. (13) No papers lasting more than twenty minutes will be permitted. Speeches will be strictly limited to ten minutes each. Manuscript of the papers read must be left with the secretary-general before the end of the sitting. The executive council shall decide as to the entire or partial publication of such papers in the transactions of the congress.

It will greatly facilitate the work of the executive if the fee is forwarded as soon as possible after the 1st of May, 1896.

SOCIETY PROCEEDINGS.

SACRAMENTO SOCIETY FOR MEDICAL IMPROVEMENT.

Regular Meeting, May 21, 1895.

The President, H. L. NICHOLS, M.D., in the Chair.

New Member.—D. McLEAN, M.D., was duly elected a member of the society.

Figure-of-Eight Suture.—Dr. W. A. BRIGGS, exhibited and demonstrated a figure-of-eight suture, which he recommended, especially in the closure of wounds after abdominal operations. The suture, when drawn together, brought the surfaces into close apposition, thus obviating the necessity of multiple or layer suture in this class of cases.

Obesity.—DR. JOSEPHINE CALLAHAN read a paper upon this subject. She said obesity, being a diseased condition, should receive the same attention that would be bestowed upon any other morbid state. Fat people were unfavorable subjects for either physician or surgeon; as a rule, they bore shock badly and took anesthetics poorly; in severe illness they did not have the same power of endurance as those of slighter build. The speaker thought that stout patients were too often dismissed with a few vague remarks about diet, exercise, early rising, etc., which directions the patient attempts to follow in an aimless way, and, becoming discouraged, looks for a medicine which will quickly reduce his weight. It required courage of a high order to persevere with a diet that would reduce the weight materially and safely. We should bear this fact in mind when prescribing a regimen for this class of cases, and make it as liberal as possible. Sugars, starches, fats and fluids should be eliminated to a great extent; but, as man naturally lived on a mixed diet, it was not wise to arrange for an exclusively animal diet. A fairly liberal dietary was then enumerated, together with a list of various articles of food which should be avoided. It was most important to avoid drinking much fluid, especially with meals, and malt liquors should be strictly prohibited. One to two ounces of Rochelle salts two or three times a week was beneficial. In conclusion, the speaker said that she was certain that any patient willing to persevere in denying himself at table, and following only a restricted diet, taking plenty of exercise and hot baths, could safely and certainly reduce his weight.

DR. J. H. PARKINSON said he believed obesity was not as common in the United States as in other countries where people were heavier eaters and drinkers. Obesity might be divided into two classes: (*a*) That in which there was an excessive accumulation of fat in an otherwise healthy organism. (*b*) The accumulation of fat with degeneration of tissues. In the latter case, little can be done in curing the disease or even in staying its progress. Where an over production of fat occurs with evidence of otherwise good health, and where the patient is in earnest in the desire to reduce body weight, much can be done by judicious dieting. Unfortunately, this class of patients are deficient in perseverance, and frequently relapse. A diminution of fat, under treatment, has often been followed by an increase of weight during relapse. A purely animal diet is probably the best that could be suggested, but with this it was necessary to give large quantities of water in order to maintain the eliminative action of the kidneys.

DR. W. A. BRIGGS said it had been suggested that the consumption of water should be reduced to a minimum. This was too empirical. Weight may be reduced in a short time by withholding liquids and by use of the hot bath, but this reduction was not at the expense of the tissues, but of the fluids contained therein. The subject would, therefore, regain weight in two or three days when returning to the usual mode of life. A material reduction will sometimes be accompanied by other symptoms which are deleterious. There will be tissue waste, overtaxing the kidneys, which organs may also suffer. The diet, as laid down by the author, could be used with safety and with good results. The decidedly obese will bear a moderate quantity of starch. Fleshy people, as a rule, are large consumers of starch.

DR. W. E. BRIGGS said if any one discovered any efficient remedy for obesity he could enlarge his practice and materially increase his bank account. American women, as a rule, abhor the idea of becoming stout. The present popular fad of bicycling is a good method for reducing superfluous fat, and he knew of several instances where a number of inches had been lost under this form of exercise.

DR. F. B. SUTLIFF questioned whether it was advisable to recommend a very stout woman to ride a wheel. He had a patient who had ridden a wheel for this purpose, and, as a consequence, had already been in bed for four weeks. He believed that by the time she was convalescent her weight would have increased instead of diminished.

DR. D'ARCY POWER had treated obesity as other speakers had suggested, by means of a meat diet and water. It was not justifiable to reduce the water to a small quantity. In conjunction he used a small amount of potash. Whether it will help in the elimination of waste products he was unable to say. Theoretically, it was an ideal treatment and had been successful where it was possible to carry it out. Nothing had been said in the discussion with reference to the surgical treatment of obesity. When practising in Oregon, he was present at an operation where forty-seven pounds of superfluous fat was removed from the pendulous abdomen of a farmer, with good results.

Dr. G. L. Simmons said there was a great deal of difficulty in making patients carry out directions in regard to diet. He mentioned the case of a man who was desirous of being treated, but when he read the directions, returned them, saying it was impossible for him to follow them. He believed it was best to leave fleshy people alone. When treated with a view to reduction in weight, there was a change in the muscles and tissues, especially in the heart muscles, and patients failed more rapidly than if left alone; the accumulation of fat beyond a certain amount being fatal. A New York physician had mentioned to him as a scientific fact that trees sometimes die of too great an accumulation of fat, the microscope showing a greatly increased number of fat corpuscles in the structure of the tree.

Dr. G. A. White said he had had two patients—both women—who were desirous of reducing their weight, but he found that in each case they wanted medicine, not any special form of diet. Bicycling was good as far as exercise was concerned, but when carried beyond the normal, will reduce. A patient of his had once lost 25 or 30 pounds in a comparatively short time by smoking to excess. This was followed by impairment of appetite and consequent reduction. He had had no personal experience with surgical procedures in this class of cases. He had never heard of an operation of this character in Sacramento.

Dr. H. L. Nichols, said it did not follow that fat people were necessarily large eaters, nor did the reverse hold true. No one could say that he was obese, and, on the other hand, probably no one ate more freely of sweets and starchy foods, etc., than he did. He had never been stout and he did not believe there was any form of diet that would make him so.

Dr. Callahan, in replying, said she had found that patients would not persevere with restrictions placed upon them. It required a great deal of courage to do so, as they suffer considerably. It was well, therefore, to make the dietary as liberal as possible, and in this way to encourage them. She believed that weak coffee and tea would be better than plain water.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular Meeting, May 14, 1895.

The President, C. C. Wadsworth, M.D., in the Chair.

New Members.—H. B. A. Kengeler, M.D.; W. J. Hawkins, M.D.; W. R. Cluness, Jr., M.D., and Henry du R. Phelan, M.D., were duly elected members of the Society.

Entertainment of the State Society.—The Committee on Entertainment of the Medical Society of the State of California, at the annual meeting held in April, made its final report, showing that, out of the appropriation made, there was, after all expenses had been paid, a balance on hand of $67.35. On motion, this amount was placed to the credit of a special entertainment fund for future use.

Dr. W. F. Cheney read a paper on "The Vaginal Secretion, and Its Importance as Regards Puerperal Fever." [To be published.]

Vibratory Treatment for Deafness.—Dr. E. S. Clarke read a paper upon this subject. He said: While for several years past the vibratory method of treatment for catarrhal deafness has been used to some extent, the literature on the subject is rather scant. I have not seen it mentioned in any of the textbooks, and only an occasional brief notice in some of the journals. From my own experiments I am satisfied that good results may often be obtained when other methods of treatment—the use of the catheter, Politzer bag, etc.—have failed. The cases benefited are not confined entirely to those having catarrhal affections, for those where the drum membrane has been destroyed by chronic otorrhea are considerably improved. My standards of measurement are, a watch heard at one meter—that is, with a normal ear, $h = 1.00$ $v = \frac{20}{20}$. For producing continuous vibrations there are a number of machines on the market—

vibrometers, vibrophones, etc. but those I have used are not satisfactory; they do not give sufficient range or purity of sound; the so-called vibrometer I have not seen, but from the diagrams it appears to be a fairly good instrument. The apparatus I use is an ordinary guitar firmly attached to a stand, with a movable electric vibrator adjusted to strike any desired string. The range of vibrations are in this, from 80 to 320 per second, and can be increased to 1,000 per second by use of frets. The strings I have found most effective, however, are those vibrating 80 to 160 times per second, though this varies considerably in different individuals. As to the volume of sound required in any particular case, I have been unable to determine unless it be that, other things being equal, ther greater volume the better the result obtained. The speaker then reported a number of cases, with a table, showing the average results obtained in about 150 cases noted by him.

CALIFORNIA ACADEMY OF MEDICINE.

Regular Meeting, April 20, 1895.

The President, WM. WATT KERR, M.D., in the Chair.

Fracture of Skull—Trephining—Loss of Brain Substance.—DR. J. F. MORSE exhibited a patient, and read the following history: J. G—— met with an accident March 28th, being struck on the forehead by the crank of an elevator, after which he was unconscious for a short time. On examination, it was found that he had sustained a fracture of the skull, extending from the apex of the orbit through the orbital plate of the frontal bone of the right side, then up over the forehead to about three inches above the orbit, where the fracture bifurcated; one bifurcation extending over the vertex, the other downward and backward toward the right parietal eminence. There was depression of the bone just above the orbit on the left side of the fracture, and the point of bone between the two bifurcations was depressed and impacted beneath the bone in front. March 30, 1895, the edges of the fractured bone extending from within the orbit up to the bifurcation were cut away, leaving an opening about three inches long and one inch wide. Through this opening an immense blood clot was removed, along with a great deal of brain matter from the frontal lobe, and the impacted or depressed portion of bone behind, between the bifurcations, was elevated. The cavity found in the frontal lobe was packed with iodoform gauze, and the wound treated by the open method.

DR. H. KREUTZMANN: This case is a very interesting one, from the extent of the fracture, the bleeding, and the success of the tamponade. While assistant, years ago, in the Hospital in Frankfort-on-the-Main, it was the custom to open up freely and remove all bone necessary in cranial fractures; it seems the only rational treatment.

DR. DUDLEY TAIT: I indorse the plan of making a free incision in all doubtful cases of head injury, and believe that elevation of temperature, as well as bleeding, calls for an operation. Removal of brain tissue without bad result is frequently met with. In a case of injury to the occipital bone, under my care, two or three ounces of cerebral tissue were removed, and no serious symptoms followed.

THE PRESIDENT: I remember a similar case in a boy 7 years old, who, in sliding down the baluster, fell four stories, striking from side to side and falling upon a stone floor, fracturing the right frontal bone: The fracture was evident to the touch. A triangular piece of bone 1½ inches long and ¾ inch wide was removed, the loss of brain substance was not extensive, and the boy made a good recovery. A large piece of cicatricial tissue covers the forehead where the bone was removed. There have been no symptoms of loss of mental power since the accident, 15 years ago. Nearly all cases of fracture of the frontal bone seem to occur on the right side, they are seldom seen on the left.

Nephrectomy for Cancer.—DR. H. KREUTZMANN exhibited a child upon whom he had performed nephrectomy five weeks before for malignant degeneration of the left kidney. The specimen had been demonstrated fresh the very day of the operation. He stated that recovery had not been uninterrupted. There were no signs of peritonitis; patient never vomited; gas and feces soon passed freely; urine was voided normally; the quantity could not be measured, since it was passed into the diaper. But a phlegmonous infiltration of the whole wound occurred, which made the early removal of the stitches necessary, and which prevented healing by a linear scar. The wound is now entirely healed, the child up and around, and he enjoys perfect health at the present time. A few data concerning nephrectomy for malignant disease of childhood were given, according to Prof. Doederlein (*Centralblatt f. Gynäcologie*, No. 10, 1894). Doederlein had successfully removed a large adeno-myosarcoma of the left kidney from a child 7 years of age, through transperitoneal nephrectomy. Doederlein found the number of cases in children, published, including his own, 47; of these 19 died (40.4 per cent), as a direct consequence of the operation; 10 from shock; five from septic peritonitis; 1 from ligation of the vena cava, with numerous metastases in the lungs, liver, and lymph glands; 2 from occlusion of the intestines; 1 from carbolic intoxication. Twenty-five children recovered from the operation, but died from a relapse of the disease. Five children only were considered cured, being sufficiently long under observation—his own case being only six months, and another being only four months after operation, could not be as yet included. Notwithstanding the doubtful prognosis, there could be no question as to the propriety of performing nephrectomy in every case wherein the disease was discovered.

Dr. Dudley Tait: Since the last meeting I have made a research for statistics of nephrectomy for malignant disease of the kidney. The most complete table is furnished by Barth, of Marburg (1892); of 100 nephrectomies, 48 died from the immediate effects of the operation, 20 from metastases, 38 were pronounced cured. The latter figure I consider subject to great doubt. None of the cases have lived over five years. In November, 1893, the question of nephrectomy for sarcoma of the kidney was thoroughly discussed at the New York Surgical Society, Abbé having presented three cases, two of which (in children) were successful; the third, in a man of 65, died from the operation. Keyes has a case having survived the operation 3½ years. In the presence of the very gratifying results already obtained in this class of cases, the propriety of nephrectomy should impress itself; the outlook is certainly encouraging. The possibility of metastases should not deter the surgeon in operating for sarcoma of the kidney. If this argument were sound, cancer of the breast should be left untouched. With reference to the method of removing a sarcomatous kidney, I think the traverse incision, a straight incision from the spine toward the median line, even crossing the rectus, if necessary, will prove the most useful and safest. The kidney can thus be handled with ease; the peritoneal cavity may or may not be opened, according to the size of the tumor. The advantages of this transverse incision over Langenbeck's and the lumbar incision are plainly visible. Trendleburg's position constitutes a very important factor in all kidney cases. Aside from the facility accorded for inspection (the patient being turned on the side), the shock is considerably lessened and drainage is assured. There is more bleeding in the transverse incision than in any other, but this may be easily controlled, and the resulting cicatrix is much firmer through union of the muscles. Subsequent hernia is quite unknown with the transverse incision. In doubtful cases, I think the choice of methods should be settled by adopting Lawson Tait's practice, "The most likely looking road." Regarding mistakes in diagnosis, I recall a case which I presented to the Academy in 1893. At the time of operating, the tumor was diagnosed as malignant disease of the kidney. It proved a malignant spleen. The patient died of hemorrage a few hours after its removal, notwithstanding the use of clamps on the pedicle.

Dr. Kreutzmann: I did not consider the lumbar operation as being the best one in my case. Of course, where there is pus, I would prefer it. About two years ago, I presented to the Academy a five pound tumor removed from a woman 60 years old. I had thought that it was a malignant tumor of the ovary. An incision was made to remove the ovary, but I found the kidney instead. In eight days the patient died. I think that stitch abscesses started a peritonitis which became purulent. The autopsy showed that the wound behind the peritoneum had healed nicely.

Dr. Tait then reported a case and presented a specimen of a pseudo-malignant ovarian cyst. He asked Dr. Kreutzmann if he found abundant ascites present in many of his ovarian cases.

Dr. Kreutzmann: We do not find it so very often. In former years, ascites was considered a contra-indication in operating, as it was thought it was a sign of malignancy of the tumor. Ascites is sometimes due to a peculiar condition of the peritoneum, described by Prof. Werth, of Keil, as a pseudo-myxoma of the peritoneum.

SPECIAL CORRESPONDENCE.

PARIS.

[FROM OUR OWN CORRESPONDENT.]

The Medical Student's Ball and its Contretemps.—Presidential Hospital Inspections.—Epidemic of Tetany at the Nanterre Hospital.—Protest of the Profession Against the New Scheme of the Assistance Publique.—The Discovery of Argon.—Interview with Prof. Stanislas Mennier.

It is certain "all is not gold that glitters." This truth is as evident in the political and medical as it is in the financial world. The morning following the medical student's ball the papers described it in glowing terms. The ex-President, the much-abused M. Casemir Perier, attended it like a good husband in company with his wife, and, like a good citizen, he was excessively affable with the rising generation, the force of France who, mustered strong on this occasion, as is always the case when a student's ball is organized. The President, M. Felix Faure, was also present, and were it not for the uncomfortable fact that "all is not gold that glitters," which throws cold water on so many beliefs, the conviction that M. Casemir Perier, ex-President of the Republic, and M. Felix Faure, President, are as united as any peace league could wish to see two brother men and two distinguished compatriots, could not have been questioned. A perfect utopian peace and good will apparently reigned at this historical medical student's ball. Now when the flourish of trumpets heralding the graces and virtues of all present has ceased, the truth comes out, and it is announced that M. Bourqueney, Directeur du Protocole, who overlooks, directs and perfects all the forms of etiquette at all of the Presidential ceremonials, will have to leave his post and accept a Consulship in Holland because he has been guilty of the inexcusable and irreparable crime of allowing the ex-President to meet the President of the Republic. It is an ill wind that blows no one good. M. Bourqueney will suffer severely for this silly disaster. M. Ribot's sangfroid was tested on this occasion. He bluntly refused to allow M. Casemir Perier a place in the cortege that faithfully followed the President going his rounds of the splendid suite of rooms at the Continental Hotel, where the ball took place. There was an inextricable confusion regarding the precedence to be given to Mme. Casemir Perier and the Ministers' wives, resulting in a general fiasco and for the moment smothered discontent, which afterwards blazed out and destroyed the Directeur du Protocole. Notwithstanding this troubled storm which has raged in a teacup, and which, in spite of its pettiness, has shipwrecked a distinguished citizen, the medical student's ball was ten times more conspicuously interesting than if the President had gone on his banal, stereotyped round of the ball-room, followed by his ministers and officers of the household, without meeting the ex-President, much-abused Casemir Perier, who on that night was reported in the daily papers to have been affable and charming, and was loudly applauded by the students. That the same enthusiasm was shown for the President goes without saying, and who can say it was not deserved. M. F. Faure gave 20 francs towards the fetes, and on the evening of the ball 40 francs to the "Maison des Estudiants" about to be constructed; moreover, he is a good President and an excellent man. All rational-minded men and women must feel surprised at this grotesque incident. M. Casemir Perier, when acting President of the Republic, was solicited by the medical students to attend their ball, and he accepted. When the time came, though no longer Chief Magistrate, he felt bound to go, and desired by his presence to manifest his interest in the students. The President of the Republic is always invited, therefore, M. F. Faure received the usual deputation of medical students soliciting the honor of his presence at their ball, and the usual acceptance was accorded them. All these facts were known weeks before the ball took place. It is therefore a mystery to straightforward ordinary mortals why some of the persons concerned did not take steps to prevent this ridiculous catastrophe which has been disastrous to M. Bourqueney, but which added to the brilliancy and success of the medical students' fete.

M. Felix Faure has announced his intention of visiting all the hospitals, and half a dozen have already been inspected. The usual compliments were paid to officials, which, let us charitably hope, are deserved. Patients have chatted with the President and have basked under the beneficent influence of his smile, and little girls have been kissed in exchange for bouquets presented by them to the President on these solemn occasions. The culinary departments have been inspected by the indefatigable President and pronounced excellent, though their results have, perhaps, prudently, not been tested. The only practical outcome of these presidential visits that has hitherto been noted is the donation to each hospital of an amount varying from $40 to $100. Whether any important or lasting benefit will accrue from them, whether any serious reform in hospital organization and administration will be made, is a doubtful question that may, perhaps, be solved in the distant future.

It is certain that the state of affairs, some of the daily papers assert, exists at the Nanterre Hospital, calls for improvement and serious investigation in order to refute the charges and apply a remedy. Such a step would bring more practical benefit to the four thousand inmates of the hospital than the President's visits, at the hospitals, where he distributes smiles and compliments, accepts bouquets, and leaves behind dribbling donations. Dr. Dujardin Beaumetz considers this asylum to be a hot bed of epidemics; the source of those which break out in Paris. An epidemic of tetany has broken out in the asylum, and is attributed by Dr. Sapelier, a distinguished physician attached to that institution, to ergot of rye contained in the bread given to the patients. The Municipal Laboratory experts have been unable to detect the presence of ergot in the suspected bread, and Dr. Sapelier's hypothesis is not accepted, but he, nevertheless, continues to maintain it. It is asserted that the inmates of the hospital are badly fed on a poor quality of food, which is served luke-warm; that the elevators used for sending the food up to the wards are also used for sending down cadavers to the dead-house. If the President were to pay an unexpected visit to the Nanterre Asylum, his hospital visits would bear a serious character, which is now conspicuous only by its absence.

The long contemplated reform in competitive examinations has culminated in a result resembling that of the mountain in labor giving birth to a mouse. The examinations for the post of House Surgeon and House Physician at the Hospitals, are to be conducted by ten Examiners, divided into two sections of five. One will examine the papers on Pathology; the other, the papers on Anatomy, and the two sections will unite and form a committee of ten, to judge the oral examination.

In consequences of the dishonest traffic in serums, made from horse serum obtained at the abbatoir, where diseased horses are slaughtered, M. Leygnes has hurried the passage of the bill regulating the sale of serum, which, it is hoped, will prevent dishonest traffic in these therapeutic agents.

The Paris hospital surgeons and physicians have protested against the public assistance plan of dividing Paris into hospital districts and compelling the poor to be treated in the hospital of their own district. They argue that the richer class can choose their medical adviser, and that the poor ought not to be deprived of this consolation. They also object to the proposed change of the hospital out-patient departments. Hitherto, the internes of the hospital wards, sometimes aided by the *Chef*, gave gratuitous consultations. Now this department is to be entrusted to young medical men, formerly internes. The hospital *Chefs* declare that the out-patients will not be so well treated; that in difficult cases the *Chef* could always be appealed to; if not present, whereas, in future, this will be impossible.

The discovery of argon by two English scientists, Lord Raleigh and Mr. Ramsay, is attracting great attention, both in the scientific world and amongst educated outsiders. A sample of this new gas discovered in the atmosphere, has been forwarded to Prof. Berthold. I have had the pleasure and privilege of interviewing Prof. Stanislas Mennier, of the Paris Natural History Museum, who expressed himself as follows: "The discovery of argon is one of the most important scientific discoveries of the present time. The discovery of a new body, which is a simple, not a composite one, is always of importance, but in this instance especially so, as the new body is one of the normal component elements of the atmosphere. Argon, notwithstanding that it is present in the atmosphere in a very small proportion, must, it may safely be presumed, fill an important part in the terrestrial economy, like its companions, oxygen, nitrogen, carbonic acid and water vapor. The signs observed in the aurora borealis, indicating the presence of argon are sufficient ground for this belief. It is especially interesting to learn that this body, though possessing feeble chemical affinities, has, nevertheless, combined with a mineral called cleveite, in which M. Hilderbrand, some years ago, observed in company with uranium, a gaseous body, which he believed to be nitrogen, but which was argon. The point of greatest philosophic interest in the history of the discovery of argon is, that the knowledge acquired concerning this body denies the principal chemical differentiation apparently existing in the composition of the terrestrial globe and of that of the sun. If, as facts seem to indicate, the new gas coincides with helium in the solar spectrum, the great principle of unity in the composition of the solar system receives a new and decided confirmation.

CORRESPONDENCE.

Medical Men and Medicine Men.

Sir: In the May issue of the *Pacific Medical Journal* appear the following editorial comments concerning an article written by me and read by the Secretary before the Medical Society of the State at its last meeting: " 'Medical Men and Medicine Men' was the title of a paper written by Dr. E. J. Overend, and read by the Secretary. It consisted of a venomous though coverted attack upon individual members of the Medical Society, and criticised the conduct and manner of the medical profession in general. It is, indeed, too bad that any physician should not be above petty jealousies. It is needless to say that the subject matter of such an essay has no place in a society nor in a record of medical science." It appears that I had the misfortune to displease Dr. Anderson's critical taste. Was it the theme or its treatment that received his censure? Surely the theme is a proper one, for it relates to ethics—and there is such a thing as the Code of Ethics, which is regarded with some respect by the profession in general; indeed, many doctors think it "a part of the record of medical science." As to the charge that my paper "consisted of an attack upon individuals," I can only say that if any individuals feel aggrieved they must certainly know that the cap fits them. I am not conscious of having written anything of a personal character; it was purely general. I merely pointed out some common medical sins, and made a plea for their abandonment. Perhaps I am presumptious, but I have an idea that had I submitted my paper to the Board of Censors they would have given their consent to its being read. In this connection I would like to point out the fact that this Board of Censors did *not* approve Dr. Anderson's strange letter to Mr. Connors, of Colorado Springs; but, on the contrary, censured him for it. As Dr. Anderson thinks that my paper "has no place in a society, nor in a record of medical science," I would like to ask him if he thinks his letter to the Colorado patient would look well "in a record of medical science." I am also somewhat in doubt as to whether his editorial booming a certain mineral water and other editorials, claiming several medical celebrities as personal friends, would ornament "a record of medical science." Perhaps I may be pardoned for mentioning the fact that several members of the State Society, all of whom are older, wiser and better men than Dr. Anderson, gave me personal and unsolicited congratulations on my paper. And one prominent member, after reading Dr. Anderson's criticism, wrote me that he thought my paper both "timely and appropriate." Evidently none of the aforesaid gentlemen felt vulnerable to the "attack." In this particular they differed from the editor of the *Pacific Medical Journal*. It is rather unfortunate for Dr. Anderson that he has offered me both the opportunity and the provocation to point to him as an "awful example." He may talk of "venom" and "jealousy," but I boldly assert that the medical profession of this city will admit the justice of this letter. Unless I am mistaken, Dr. Anderson will again hear from the Board of Censors, and his colleagues will require larger quantities of whitewash to cover his record. In conclusion, I will say that my critics, instead of feeling wroth with me for holding up to scorn the ordinary medical sinner, should rather be thankful that I did not refer specifically to the man who, while holding a professorship, stoops to writing prescriptions in cipher; that he should commend me for sparing the medical editor who sells his editorials; that he should feel grateful to me for refraining from mentioning the regular physician who "stands in" with a nostrum manufacturer to get patients, and in divers devious ways featly foots it around the ethical stump after the coveted fee. I am, etc., E. J. OVEREND.

Eighth and Clay streets, San Francisco.

REVIEWS AND NOTICES.

ANTISEPSIS AND ANTISEPTICS. By Charles Milton Buchanan, M. D., Professor of Chemistry, Toxicology and Metallurgy, National University, Washington, D. C., with an introduction by Professor Augustus C. Bernays. The Terhune Company, Newark, N. J., pp. 352.

In this small book the history of antisepsis and antiseptics from the earliest times up to the present is written in a very interesting manner. There is also given a detailed account of the various antiseptics, with an estimate of their value. The interest of the book is marred by the very evident attempts to advertise a product of the Dios Chemical Co., called Sennine. The book, however, contains much useful information, and will serve for reference regarding the various antiseptics.

THE POCKET ANATOMIST. By Henri C. Leonard, M.A., M.D., Professor of Gynecology Detroit College of Medicine. Detroit: The Illustrated Medical Journal Co.; with 193 illustrations; leather; price, $1.00.

The author states that this work is intended mainly as a dissecting room companion. The larger portion of the work is simply "Gray" condensed and transposed, but much additional matter has been drawn from other sources. The book is neatly bound with flexible covers and is printed on thin but strong paper. The printing is excellent, though not so clear as it might be, on account of the thinness of the paper. The plates are all excellent reproductions of those in "Gray." In the plan of the book there are given: (1) Dissection Hints. (2) Descriptive Anatomy. (3) Visceral Anatomy. (4) Points Worth Remembering. (5) Osteology. (6) Action of Muscles. (7) Triangles and Spaces. The book is of convenient size and will be very useful to students of anatomy.

A MANUAL OF BANDAGING, ADAPTED FOR SELF-INSTRUCTION. By Henri Leonard, M. A., M. D., Professor of the Medical and Surgical Diseases of Women, and Clinical Gynecology, Detroit College of Medicine. Sixth edition, with 139 engravings. Detroit: The Illustrated Medical Journal Co.; pp. 189; price, cloth, $1.50.

The appearance of the sixth edition of this work is good evidence of its popularity among students and practitioners. The text and illustrations are quite clear, enabling a student to readily apply any of the dressings without further instruction. Chapters on "Knots," "Poultices," "Strappings" and "Immovable Bandages" are also given. It may be said that no book can take the place of actual practice in bandaging. Any work on the subject must serve simply as a book of reference while practising the art of bandaging. The art is acquired only by practice.

HOME TREATMENT FOR CATARRHS AND COLDS. A handy guide for the prevention, care and treatment of catarrhal troubles, cold in the head, sore throat, hay fever, hoarseness, ear affections, etc. Adapted for use in the household, and for vocalists, clergymen, lawyers, actors, lecturers, etc. By Leonard A. Dessar, M.D., visiting laryngologist to St. Mark's Hospital, and to the Mt. Sinai Hospital Dispensary, etc., etc. (Illustrated). New York Home Series Publishing Co.

This is a neat volume of 118 pages devoted to a description of the common throat, nose and ear diseases, together with various treatments for these diseased conditions. The subjects are treated in an elementary manner to suit the comprehension of the class of readers for which it is intended. The only adverse criticism that can well be made to the work is that it attempts too much in advising remedial treatments for conditions of which the patient can have no exact knowledge. The patient's welfare is not enhanced by such practice, as he too often uses treatment inappropriate on account of the inevitable ignorance of pathology. The only medical works that can safely be placed in the hands of lay readers are those on the hygienic care of their organs. When it comes to the treatment of actual disease, the physician, and not some medical book, should be consulted.

NOTES ON THE NEWER REMEDIES, THEIR THERAPEUTIC APPLICATIONS AND MODES OF ADMINISTRATION. By David Cerna, M.D., Ph.D., Demonstrator of Physiology and Lecturer on the History of Medicine in the Medical Department of the University of Texas; formerly Assistant in Physiology, Demonstrator of and Lecturer on Experimental Therapeutics in the University of Pennsylvania. Second edition, enlarged and revised. Philadelphia: W. B. Saunders. pp. 254. Price, $1.25.

Two years ago we had the pleasure of calling the attention of our readers to the first edition of this work, and the hopes we expressed at that time appear to have been fulfilled. We do not know of any work which can keep the practitioners of medicine so thoroughly posted on the therapeutic value of the remedies that are being introduced daily. This second edition is even more complete than the first, and is an absolute necessity to the medical man who desires to keep himself familiar with modern therapeutic agents.

COD LIVER OIL AND CHEMISTRY. By F. Peckel Möller, Ph.D. New York: W. H. Schieffelin & Co. pp. 508.

This extensive work is probably the most complete treatise on cod liver oil that has been published in the English language. The book opens with a short history of Norway and a sketch of the Norwegian fisheries, both of which will be found much more interesting to the practitioner of medicine than the 500 pages of figures showing the different chains of atomic links that can be formed. Every medical man will agree with Dr. Möller that it would be of some advantage if he could devote more time to chemistry, but the fact remains that the physician has not the time to study all the subjects that are distinctly within his own sphere of action, and, consequently, we fear that the pages on chemistry will be neglected. The work will do much to reëstablish cod liver oil in the place it occupied before the enterprising manufacturer introduced his substitutes, which were more palatable and less efficient than pure oil.

BOOK OF DETACHABLE DIET LISTS FOR ALBUMINURIA, ANEMIA AND DEBILITY, CONSTIPATION, DIABETES, DIARRHEA, DYSPEPSIA, FEVERS, GOUT, OR URIC ACID DIATHESIS OBESITY, TUBERCULOSIS, AND A SICK-ROOM DIETARY. Compiled by Jerome B. Thomas, B.A., M.D., Visiting Physician to the Home for Friendless Women and Children, and to the News-boys' Home; Assistant Visiting Physician to the Kings County Hospital, etc. Philadelphia: W. B. Saunders. Price, $1.50.

This consists of a volume of detachable diet lists which the physician can furnish to the patient who is suffering from any malady that necessitates special care in relation to diet. The arrangement of the book is excellent, but a careful revision of the lists is necessary before they can be used for their intended purpose. There are very few medical men at the present time who prescribe eggs as one of the preferred foods in Bright's disease, yet this is done in the diet list furnished to us; it is also said that the patient may take stimulants, the only ones against which he is cautioned being "coffee, malt liquors, and spirituous liquors," a state of affairs which leaves the patient in doubt as to whether he may not take wines, as the term "spirituous liquors" is popularly supposed to refer to whisky and brandy. Under the head of diabetes the patient is told in the regular list that he may substitute potatoes for bread, and further down on the same page he is told to avoid potatoes; where a relaxation of strict diet is contemplated it is better to leave this to the physician instead of confusing the patient by giving him printed instructions which must appear to be contradictory. In the diet for gout the patient is told that he may take peas, and then that; he "must avoid peas." Much confusion of the above nature would be avoided if under the head "may take" were included only such articles as may be taken by every patient suffering from the disease; then to the words "must avoid" add—unless specially permitted; and lastly, add a third head—articles specially permitted, under which the physician would from time to time write the names of such articles as the condition of the patient permitted.

Wm. R. Warner's Therapeutic Ready Reference Book for Physicians. Philadelphia: Seventh edition. pp. 120.

This is practically a list of formulæ, incompatibles, instruction in prescription writing, etc., published by Wm. R. Warner, with the object of advertising their preparations. It is simply a neat souvenir from one of our best manufacturing pharmacists.

Fairchild's Hand-Book of the Digestive Ferments, as remedies *per se*, as surgical solvents, and in the peptonization of milk and other foods for the sick, and for the modification of cow's milk by the Fairchild process. New York: Fairchild Bros. & Foster. pp. 128.

This pamphlet, in addition to advertising Fairchild's preparations, gives much information concerning the methods of preparing easily digested foods. The chapter on infant feeding by means of humanized milk is specially interesting, and will be of use to every one whose practice leads them to deal with what is frequently a very difficult problem—the nutrition of a hand-fed baby.

A Synopsis of the Practice of Medicine, by William Blair Stewart, M.A., M.D., Lecturer on Therapeutics; late Instructor in the Practice of Medicine in the Medico-Chirurgical College of Philadelphia; Demonstrator in the Philadelphia School of Anatomy, etc. New York: E. B. Treat. pp. 434. Price, $2.75.

It is very questionable whether books of this kind repay the writer for his work, as at the very best they are incomplete and unsatisfactory. Certainly they are not of much advantage to the practitioner who has already laid the foundation of his learning, and must require something more extensive than can be contained in a synopsis of the present magnitude. Dr. Stewart's volume is an excellent book of its kind, but we can hardly recommend it to any one except junior students, who can receive from it much information that will assist them in subsequent reading and lectures.

Dose-Book and Manual of Prescription-Writing, with a list of the official drugs and preparations, and also many of the newer remedies now frequently used, with their doses, by E. Q. Thornton, M.D., Ph.G., Demonstrator of Therapeutics, Jefferson Medical College of Philadelphia; Acting Assistant Surgeon, United States Marine Hospital Service. Philadelphia: W. B. Saunders. pp. 334. Price, $1.25, net.

There is nothing in this book that should not be found in every standard work upon pharmacy. The information contained is no doubt valuable, indeed we may truly say absolutely necessary, to the medical practitioner; but we regret to see this further instance of the endeavor to multiply the number of books upon the doctor's shelf, until we seriously doubt whether the majority of medical works are not written for the benefit of the publisher rather than that of the doctor. Any one who wishes a special volume upon dosage and prescription writing cannot do better than purchase this book.

REPORTS, ANALYSES AND NEW INVENTIONS.

The King Thermometer Fountain Syringe.

We have received from the Chas. Roome Parmele Co. one of their "King Fountain Syringes," with thermometer attachment. The syringe is one of the ordinary fountain pattern, with open neck, having a capacity of one gallon. Attached to the lower part of the front of the bag is a rubber bulb containing a thermometer, the scale of which projects above in plain view. To avoid cracking the thermometer, some cold water is first placed in the bag, and then hot water added until the desired temperature is secured. Alongside the thermometer is printed the standard temperature for an enema for patients between the ages of one and seventy. This seems to be a practical and very desirable improvement. There are many occasions on which a douche, whether vaginal, intra-uterine or post-operative is required, when the temperature of the water is of considerable moment This is especially true with intra-uterine and intra-abdominal work. By using this syringe, as we have demonstrated in practice, the actual temperature of the douche can be instantly noted, and this is a matter of considerable satisfaction, as well as a point of great importance. The capacity of the apparatus, one gallon, is sufficient for thoroughly flushing the bowel, and the presence of the thermometer prevents any error in the temperature of the enema. The syringe is well made and, when complete with a rectal and a vaginal nozzle, retails for $2.25.

MEDICAL NEWS.

LICENTIATES OF THE BOARD OF EXAMINERS.

At a meeting of the Board of Examiners, held June 4, 1895, the following were granted certificates to practise medicine in this State:

O. Willington Archibald, Jamestown, N. D.; Coll. Phys. and Surg., Keokuk, Ia., Feb. 23,'70.
John W. Bacon, Los Angeles; Rush Med. Coll. Ill., Feb. 3,'69.
Willington C. Burke, Los Angeles; Univ. Med. Coll., Kansas City, Mo., Mar. 22,'92.
Bruce L. Calhoun, Verona, Pa ; Cincinnati Coll. Med. and Surg., O., June 6,'76.
H. M. Cox, Redondo Beach; Coll. Phys. and Surg., Keokuk, Ia., Feb. 17,'76.
Andrea De Lucis, San Francisco; Royal Univ., Turin, Italy, Dec. 7,'81.
Thos. J. Dills, Ontario; Med. Dept Univ. of Mich., Mar. 29,'71.
Edward H. Lake, Alameda: St. Louis Coll. Phys. and Surg., Mo., Mar. 26,'95.
Thaddeus L. Loofbourrow, Eureka; Rush Med. Coll., Ill., Mar. 25,'90.
Kenneth William Millican, Los Angeles; Royal Coll. Surg., England, Nov. 19,'79; Royal Coll. Phys., Ed., Scotland, July 7,'80.
Thos. J. Pierce O'Brien, Los Angeles; McGill Univ., Montreal, Canada, Mar. 31,'82.
Edward E. Perrault, San Francisco; Med. Dept. Univ. California, Nov. 10,'85.
John H. Philip, Oakland; Bellevue Hosp. Med. Coll., N. Y., Mar. 25,'95.
G. Schiff, San Francisco; Univ. of Wurzburg, Germany, Jan. 26,'56.
Geo. M. P. Vary, San Francisco; St. Louis Coll. Phys. and Surg., Mo., Mar. 26,'95.
Sherman Voorhees, Dagget, Pa.: Coll, Phys. and Surg., Baltimore, Md., April 21,'93.
Geo. B Wilson, Pullman, Wash.; Cooper Med. Coll., Cal., Dec. 6,'92.
Edward H. Woodruff, Los Gatos; McGill Uuiv., Montreal, Canada, April 1,'90.

REFUSED.

Dora W. T. Kremser, San Bernardino; insufficient credentials.

CHAS. C. WADSWORTH, Secretary.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department of the U. S. Army (Division of the Pacific) from May 20, 1895, to June 20, 1895.

Captain William J. Wakeman, Assistant Surgeon, upon being relieved from duty at Fort Thomas, Ky., will, upon the expiration of the leave of absence granted him, report for duty at Fort Huachuca, Arizona.

So much of the order as directs Captain Rudolph G. Ebert, Assistant Surgeon, to report in person to the commanding officer of Fort Columbus, New York, for duty at that post, is amended to direct him to report for duty at Vancouver Barracks, Washington, relieving Capt. William H. Arthur, Assistant Surgeon. Captain Arthur, on being thus relieved, will report for duty at Fort Columbus, New York.

Leave of absence for one month and fifteen days, to take effect on his arrival in New York City, *en route* to his station in the Department of the East, is granted Major Timothy E. Wilcox, Surgeon, U. S. Army.

Leave of absence for one month and twenty days, to take effect on or about August 10, 1895, is granted Major Louis M. Maus, Surgeon.

Captain Edwin F. Gardner, Assistant Surgeon, is relieved from duty as attending surgeon and examiner of recruits, in Boston, Mass., and will report in person to Colonel Charles H. Alden, Assistant Surgeon-General, President of the Examining Board appointed to meet in Washington, for examination by the board as to his fitness for promotion, and, upon conclusion of his examination, will report for duty at Fort Grant, Arizona.

Captain Walter D. McCaw, Assistant Surgeon, will accompany Troop C, 4th Cavalry, on its march from the Presidio of San Francisco to Monterey and during its stay in camp. Par 1, S. O. 79, Dept. of Cal., June 20, 1895.

The leave of absence for seven days granted Captain Ogden Rafferty, Assistant Surgeon, in Orders No. 2, current series, Camp A. E. Wood, Wawona, California, is extended fourteen days. Par. 1, S. O. 70, Dept. of Cal., June 4, 1895.

ITEMS.

Dr. A. S. Bower, of Salt Lake City, has removed from the Central Block to 253 S. West Temple street.

Dr. Wilbur M. Swett will have charge of Dr. Barkan's practice during the absence of the latter in Europe.

Dr. A. G. Deardorff has removed from Fresno to San Francisco, and has opened an office at 14 Grant Ave. The doctor will in future engage entirely in special work in connection with diseases of the rectum and genito-urinary organs.

The Atkinson Medical Society Register.—Dr. W. B. Atkinson, of 1400 Pine street, Philadelphia, Pa., has now in press his Register of Medical Societies. It is desirable that no society be omitted, and the publisher requests that secretaries of societies will promptly furnish him with data for publication.

A Double Education.—The following is credited by the Kern City *Standard* to Henry Miller, the surviving partner of Miller & Lux. Many years ago Mr. Miller was approached by a young M.D., who had located in Los Baños and desired to make an impression on the wealthy rancher. "I would be pleased, Mr. Miller, to have you call on me when you require the services of a physician. You can repose perfect confidence in me as I have received what might be called a double education; that is, I have studied homeopathy, and am also a graduate of a regular medical school." "Ah. dot vos noding," replied Miller. "I had vonce a galf vot sucked two cows, put he mate noding put a gommon sdeer after all " This homely truth is an excellent example of the results attained by the so called "liberal homeopath," and is a good thing for new code advocates to ponder over. Mr. Miller knew nothing about 'pathies, but he had lots of "horse sense."